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**‘Knotworking’ and ‘not working’: a realist  
evaluation of a culture change intervention with  
a frontline clinical team in an acute hospital**

A project submitted to Middlesex University in  
partial fulfillment of the requirements for the degree  
of Doctor of Professional Studies

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## Abstract

Culture change and teamwork are often cited in healthcare policy and research as central to improvements in patient care. A critical review of the literature suggests that theory is insufficiently used to inform culture change or team development interventions. Culture change interventions are rarely evaluated in implementation research with few rich qualitative accounts of clinical team development in context.

This case study drew on the principles of realist evaluation to identify what worked, or did not work, for whom, in what circumstances in relation to an eighteen-month culture change intervention that had been carried out with a frontline clinical team identified as being in difficulty. It addressed the following research questions using multiple methods in a pragmatic and reflexive way:

1. How does a clinical team identified as being in difficulty experience a change process directed at changing team culture?
2. How do collaborative change processes engender culture change in the context of teams in difficulty?

Conventional problem-solving approaches to team development were found to reinforce existing patterns of deficit relating leading to a critique of organization development practice. The project found that different contextualized experiences had different effects on the learning behaviour of the team and on the leadership-followership relationship. A critical appreciative approach and narrative methods were found to create psychological safety for a collaborative inquiry to take place. Building on previous theoretical research, the study proposes a reconceptualization of experiences of teamwork as emergent states of “*knotworking*” and “*not working*”.

The project offers a framework for realist evaluation with clinical teams in difficulty. It recommends that intervention and evaluation are collapsed into a single approach of collaborative inquiry, and has provided easy to use resources for clinical teams to evaluate and improve their team culture in a climate of psychological safety. A practice model of creating a critically appreciative space is proposed and described. Narratives of patient care emerged as a source of generativity for team development, which led to reflections about how patient experience and involvement might support future team development interventions and directions for research.

## **Acknowledgements**

*“Use of correct knots can make life easier. There are literally hundreds of knots, some are very specialist having only one application, whilst others can be used for many jobs. Tremendous satisfaction can be gained from solving a problem by using the correct knot. The advantages of tying a correct knot are as follows:*

- *Security and peace of mind*
- *Economy of rope or cord*
- *Better chance of unfastening the knot for re-use of the cord”*

From *Survival Advantage* (1992) by Andrew Lane

Firstly, I would like to express my deep gratitude to and appreciation for the clinical team who participated and became co-researchers in this evaluation: for their generosity in sharing their thoughts, feelings and experiences, and in creating and experimenting with new ways of working together in the middle of an intense clinical schedule. Learning about your commitment to your patients and each other has affected me profoundly.

I would also like to say a big thank you to the clinical and managerial colleagues of the team who contributed, trusted and worked alongside us to create the conditions for the research to take place and develop.

Thank you to my immediate colleagues, Dr Maxine Craig, Dr Susannah Cook and Andrew Moore, for providing invaluable peer support, time, guidance and belief in me throughout the research process, and to Angela Carr and Ewa Wojciechowska, for supervision, all of which allowed me to unknot myself on a regular basis.

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## **Chapter One: Packer's knot – used for making the first loop around a package - introduction**

### **Political context**

The NHS policy framework commits all practitioners to seek to improve the quality of services offered to patients:

*“Our core purpose remains the delivery of improved quality for our patients, by improving safety, effectiveness and patient experience”* (Nicholson, 2010, p2)

This maintains the vision set out in “High Quality Care for All” for:

*“An NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart.”* (Darzi, 2008, p7)

Tension exists between service delivery under time and financial pressure, and evaluative practices that deliver quality improvement. This is a dilemma for NHS practitioners and it seems that evaluation, particularly formative, is often abandoned in favour of delivery. Cook (2009) highlighted scant evidence of service improvement evaluation and Sharp (2005) drew attention to *“a need to make evidence more accessible, contextualised and implementable”* (piii) in improving public sector delivery. In a climate of intense cost pressure and structural change, thorough and meaningful research and evaluation can be overlooked with an over-reliance on quantitative measurement alone. The human cost of such an over-reliance was highlighted by the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013). The report has put the concept of culture, and specifically hospital culture, at the centre of debate about improvement in the NHS.

*“While the theme of the recommendations will be a need for a greater cohesion and unity of culture throughout the healthcare system, this will not be brought about by yet further “top down” pronouncements but by engagement of every single person serving patients in contributing to a safer, committed and compassionate and caring service.”* (The Mid-Staffordshire NHS Foundation Trust Public Inquiry, 2013, p18)

As Robert Francis noted:

*“Healthcare is not an activity short of systems intended to maintain and improve standards, regulate the conduct of staff, and report and scrutinise performance.”* (The Mid-Staffordshire NHS Foundation Trust Public Inquiry, 2013, p7)

Yet these systems failed to ensure basic standards of care for patients in Mid-Staffordshire. The report challenges the NHS to find ways of ensuring that its culture never loses sight of safe and compassionate care for patients. It recognizes that culture is about people operating within systems and that the answers have to come from the people within those systems. The report also recognizes that a supportive environment for staff allows them to create supportive environments for patients.

### **My professional role in the NHS**

I came to work in the NHS in 2008 when I was appointed to my current role as an organization development practitioner within a Foundation Trust with the remit of leadership and team development. I began my career in organization development in 1997, as a self-employed leadership and team development practitioner in the private sector. At the same time I undertook professional training in integrative psychotherapy, which I completed with an MSc and UKCP registration in 2003.

The skills and knowledge required of a psychotherapist seemed to me transferable and relevant in organization development more generally, and I was troubled by the lack of boundaries exercised by practitioners who explored personal issues with participants without a clear psychological contract. There was a central focus on ethics in my psychotherapy training, which seemed equally important but absent from organization development practice. For my MSc dissertation I reviewed the literature on the application of psychotherapeutic principles to management development. My research suggested that the context and boundaries of a developmental alliance might change between practitioner and client, but that the relational foundation of the work was similar. I recommended a code of ethics for organization development practice and continuing professional development through reflection and supervision.

In my organization development practice, I experimented actively with a consultancy model that was transparent about the use of psychological models and based my approach on the work of the Tavistock Institute (Obholzer and Roberts, 1994), Kolb (1984), Argyris and Schon (1978), and Edgar Schein (1999). I arranged regular supervision for a group of colleagues to support our practice. We developed a coaching skills programme for Kraft Foods plc, which we ran for five years throughout Europe, training a group of European consultants to deliver the programme in their own languages. Between 2004 and 2008 I consulted to a newly formed public-private partnership called Working Links. I began by coaching the Chief Executive and provided facilitation to the senior executive team who had found

it difficult to establish a shared culture, coming from widely different professional settings.

It was through a mutual professional acquaintance that I was introduced to the organization development team at the Trust in 2005. At that time, they were developing expertise in facilitating team process following a challenging situation with a team that had undermined the functioning of a flagship service. The head of organization development commissioned me to facilitate a series of action learning sets to help the team reflect on their work and to learn new frameworks for understanding and working with team process. I provided a supervisory role as they worked with a number of clinical teams in difficulty. One of these was a frontline multi-disciplinary team who provided interventions and scans for a consultant led acute hospital service which subsequently became the research setting for the study.

Their work was highly specialized which had led to isolation over the years and the staff shared little service development or time with other similar services in the hospital. They spoke about external services with hostility and sarcasm. The team had developed its own culture that was distinct and characterized by its difference to other similar services within the same organization. The senior leaders of the organization had promoted autonomy for services throughout the past twenty years, which had led to a multiform organizational structure, with little standardization of cultural norms and practices. This had led to strong identification of staff with their particular service, but not with the organization.

The team's working environment was accessed from the main corridor of the hospital and other staff had no reason to visit or pass through. When I arrived 18 months before this project started I felt that the staff were suspicious about external interest in the service. This was unsurprising, given that a large number of staff had been downgraded in the previous eighteen months due to a service review.

The team had their own seminar room, so any teaching and meetings happened within the unit. They reported that there were few meetings or teaching. The environment was entirely neutral; this could have been any hospital department in any hospital. There appeared to be no particular care, ownership or pride in the physical environment. There was little natural light due to the nature of the service. Patients who were waiting were transported cheerfully by the porter but otherwise looked lost next to the reception desk. There was a staff tearoom that was neat,



lacking in character and didn't seem to be used. The allied health professionals spent most of the day in a series of dark rooms overseeing patient tests using highly technical equipment, and I felt unwelcome and out of place whenever I entered. The conversation clearly stopped and everyone was unnaturally quiet.

The nursing staff spent most of the day in the room where interventions took place and didn't mix much with the allied health professionals. The medical consultants each had their own office and only popped their head into the darkened rooms to tell or request a test or examination. Their manner was generally neutral or hostile towards the staff and me. Their relationships with the team were entirely task focused and transactional. The team manager sat in a cupboard space off one of the darkened rooms to complete his management tasks and spent most of his time involved in clinical work.

Against such a backdrop of teams in difficulty, I was impressed by the commitment of the organizational development team to professionalism, ethical engagement and developing their expertise by reflection, discussion and conducting their own doctoral practitioner research. In 2008, I applied for my current role, keen to explore the developmental potential of creating relationships as an embedded practitioner, rather than an external consultant. I wanted to undertake doctoral research and the Trust committed to support me.

### **Outline of the evaluation project**

This project evaluated a culture change intervention that was designed to support the frontline clinical team described above. The team had chronic cultural difficulties that had reached crisis point, which were reported formally by its managers and consultants and informally by other team members. I undertook a realist evaluation following the intervention in order to understand what worked, or did not work, for whom, in what circumstances and how (Pawson and Tilley, 1997). Realist evaluation is suitable for learning about change interventions as it is founded on the principle that interventions are multi-layered social interactions that are embedded in a complex social reality.

Since the inception of the project there have been multiple external change interventions in NHS hospital trusts to address problems with quality of patient care. High performing clinical teams, also known as clinical microsystems, are critical for the provision of quality healthcare:

*“...the small, functional, front-line units that provide most health care to most people. They are the essential building blocks of larger organisations and of the health system. They are the place where patients and providers meet. The quality and value of care produced by a large health system can be no better than the services generated by the small systems of which it is composed.”* (Nelson et al, 2002, p473)

Studies suggests that conflict and disruptive behaviour in clinical teams lead to poor morale, increased staff stress and sickness, and have a detrimental effect on patient safety (Sexton et al, 2000, Kauffmann, 2005, Leape and Fromson, 2006, West et al, 2006). However, there is little published evaluation research on interventions that develop positive team relationships and a supportive team culture from a historical position of low morale and fragmented relationships.

This report offers a rich, qualitative insight into the experiences of a clinical team involved in an external intervention that I led as an organization development practitioner. As a practitioner researcher with an on-going relationship with the team, I had privileged access to carry out the evaluation with them over a period of time and was mindful of the ethical sensitivities this demanded. Detailed case studies that evaluate healthcare team development interventions are scarce, despite the widely accepted importance of team communication and collaboration to the quality of patient care. I believe that this is the first realist evaluation of a culture change intervention for a healthcare team.

### **Nature of the project's development**

The project was neither linear nor cyclical in its development, activity and writing up. Rather its iterative and experiential nature is more closely captured by the notion of epiphanies or moments of sudden clarity, as unconscious processes became available to conscious awareness and sense-making, responding to emergent realities and reflexive intrapersonal and interpersonal processes. I changed my methodology from an evaluation using emancipatory action research, to a realist evaluation as a result of an epiphany, which occurred as I considered the nature of what had actually occurred in my project, and read more about realist evaluation. I used:

*“multiple data sources and methods in a pragmatic and reflexive manner to build a picture of the case and follow its fortunes.”* (Greenhalgh et al, 2009, p391)

Whilst the project evaluated what worked, or did not work, for whom, in what circumstances and how, it was collaborative and sought to benefit participants. Unlike emancipatory action research, any culture change was a by-product rather than the primary purpose of the project. I used the principles of realist synthesis (Rycroft-Malone et al, 2007, McCormack et al, 2013) to purposively revisit the literature after I had completed the project activity to question my findings and theoretical formulations.

This is the nature of work-based learning and practitioner research; I drew on evidence from published research, participants' experiences, my "*professional craft knowledge*" (Titchen and Errsner, 2000), and knowledge of the local context (Rycroft-Malone et al, 2004). Practitioners evaluate their professional practice in a formative and collaborative way on a daily basis. Such experiential learning is pervasive but often devalued as it is neither codified nor the product of propositional knowledge (Eraut, 2004). In terms of evaluation, practitioners' tacit knowledge is an enormous untapped resource (Meerabeau, 1995). Practitioner research has a role in providing a broader evidence base in implementing patient-centred care:

*"bringing together two approaches to care: the external and scientific and the internal, intuitive"* (Rycroft-Malone et al, 2004, p81).

## **Report structure**

Given the nature of the project, I have structured and written the report to convey the emergent nature of its design, activity and findings. The terms of reference and research questions addressed by the evaluation are set out in Chapter Two. These are situated in a literature review of studies relevant to the theoretical and practical debates about culture, teamwork, change interventions and evaluation in healthcare. In Chapter Three, I set out my ontological and epistemological positions to evaluating the intervention, including a description of the intervention. I explore the insider nature of the research and the implications this had for design and methods, in particular ethics and reflexivity in relation to the research process. The research took place in three phases and each phase of project activity and its unfolding findings is described in a separate chapter (Chapters Four to Six) as follows:

- Phase One: Gaining awareness of the context, mechanisms and outcomes of the organization development intervention from multiple viewpoints;
- Phase Two: Piloting an appreciative inquiry approach to evaluation;

- Phase Three: Discovering the team's positive core and refining theory about what works for whom and how.

I include an extended section on the refined realist evaluation findings in relation to the original research questions at the end of Chapter Six. The threads of the findings are drawn together and discussed against the backdrop of the literature reviewed and the original scope of the evaluation in Chapter Seven. I critique the culture change intervention in the light of the findings, and propose a socio-psychological model of the team's cultural patterns. The limitations of the design and methods used are considered. The process and findings of the project led me to develop a series of recommendations for development practice and realist evaluation with frontline clinical teams in difficulty, which are also presented in this chapter. The final Chapter Eight draws conclusions and makes recommendations for future practice and research.

## **Chapter Two: Clove hitch – a knot used to attach a rope to an object - terms of reference, objectives and literature review**

*“Change is a journey, albeit the kind of journey that often lacks a clear direction, destination or even known balance of advantage of end over beginning.” (Bate, 2004, p35)*

### **Introduction**

I begin this chapter by setting out the project's terms of reference, objectives and research questions. I continue with a literature review that critically analyzes the research and theoretical work that shaped and informed the project during its development, project activity and findings. As I was concerned with evaluating a team level culture change intervention, I focused my search strategy on theory and research into culture change in healthcare, and theory and research into developing team effectiveness in healthcare. I used the variety of search engines available through NHS OpenAthens and Summon, Middlesex University library and ebrary, using the keywords “interprofessional” and “multiprofessional”, “team effectiveness”, “teamwork”, “team development”, “team culture” and “healthcare”. I conducted separate searches using the key words “realist evaluation” and “healthcare”, and for “culture change” and “healthcare”. The latter led to a strand of organization and organization behaviour literature concerned with organization culture change. I chose not to examine broader literature on organizations and organizational behaviour in depth as I was particularly interested in the micro-context of team behaviour change. My search strategy, like the project design and development, was organic, unfolding and informed by my personality, preferences and interests.

The literature is reviewed under the following headings:

- Organizations and organizational behaviour;
- The discourse of culture change in the NHS;
- Concepts of team, teamwork and team effectiveness;
- Research into interventions that promote team effectiveness in healthcare;
- Socio-psychological research and theory of group dynamics;
- Relationships, communication and conflict in healthcare teams;
- Evaluations of interventions to improve team culture in healthcare;
- Realist evaluation of interventions in NHS clinical settings.

## **Terms of reference and objectives of the project**

I undertook the project in a large acute teaching hospital where I have worked as an organization development practitioner for five years. Prior to the project I had led an eighteen-month culture change intervention to support a clinical team that had been identified as a “team in difficulty”.

The aim of the project was to understand the processes and outcomes of a multi-faceted culture change intervention with a team experiencing low morale and interpersonal conflict. It examined the impact of the intervention on various stakeholders, on the context of care, and identified improvements in development practice. As the evaluation phase of the intervention, the research sought to empower team members through a person-centred, collaborative and emancipatory approach.

I used a realist evaluation methodology to identify what worked, or did not work, for whom, in what circumstances and how (Pawson and Tilley, 1997) in order to address the following research questions:

1. How does a clinical team identified as being in difficulty experience a change process directed at changing team culture?
2. How do collaborative change processes engender culture change in the context of teams in difficulty?

The products are:

- an evaluation of the contexts, mechanisms and outcomes of the intervention to identify what worked, or did not work, for whom, in what circumstances and how;
- qualitative evidence about participants’ experience of a team-level culture change intervention to supplement quantitative measures already in place;
- recommendations for improvements in development practice with clinical teams in difficulty;
- a framework for evaluating future culture change interventions with clinical teams in difficulty;
- contribution of new knowledge about realist evaluation in healthcare through an in-depth practice-based single case study.

## Literature Review

### Organizations and organizational behaviour

Organizational behaviour is a multidisciplinary field of study that researches human behaviour in organizations at an individual, group and organizational level. Research is aimed at understanding human behaviour and the practical application of this knowledge to enhance organizational effectiveness and individual well-being. This study was focused on researching the group level of organizational behaviour, whilst recognizing that individual and organizational processes were relevant factors. The isolation of this team from the wider organization was in itself a key contextual factor that led to the dysfunctional behaviour that members of the team reported.

Understanding and prevention of dysfunctional behaviour in organizations is a current rich strand of research, particularly in the light of unethical behaviour in the banking sector (Trevino et al, 2014). The Report of the Mid-Staffordshire NHS Foundation Trust Inquiry (2013) suggests that unethical behaviour is a systemic problem for the NHS. Dysfunctional organizational behaviour can be conceptualized at individual, group, organizational or institutional levels, according to MacKenzie et al (2011). However not all behaviour labeled as dysfunctional is necessarily unethical, depending on the ethical climate of the organization more generally. The experience of whistleblowers who are often labeled as deviant and bullied within organizations when they seek to expose organizational wrong-doing points to the organizational power of social pressures to conform. Workplace incivility has the capacity to negatively impact on the psychology and affect both of the instigator and the victim (Cortina, 2008) and may become an accepted and socialized norm in the organization (Estes and Wang, 2008). Unethical behaviour has the capacity to evolve from an individual or team characteristic to corrupt practices at an organizational and institutional level if the wider organization culture facilitates the socialization of such behaviour:

*“an analysis of the literature revealed that dysfunctional organizational behaviour is observable at the individual, organizational and institutional level and the impact of such dysfunctional behavior can range from mere annoyance to organizational destruction.”* (MacKenzie et al, 2011, p351).

Therefore the literature review focused on the organizational behaviour literature relating to organizational culture, and group and team behaviour in organizations.

### **The discourse of culture change in the NHS**

The discourse of culture change in the NHS is politically contested, heightened most recently by the Mid-Staffordshire NHS Foundation Trust Public Inquiry and subsequent media speculation about a healthcare system that led to such grave failures in patient care:

*“The extent of the failure of the system shown in this report suggests that a fundamental culture change is needed... it requires changes which can largely be implemented within the system.”* (The Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry, 2013, p5)

Culture change is invoked frequently as a means of improving quality and performance in NHS policy documents but notions of culture are often unclear (Mannion et al, 2008) as is the nature of the change required: whether it is first order change (a change *in* culture) or second order change (a change *of* culture) (Scott et al, 2003).

Organizational culture emerged as a discourse and field of study in the 1980s, when a series of popular business books spread the view that in order to be successful companies needed to focus on their culture (Mannion et al, 2008). Culture change was seen as a way to improve productivity and efficiency at work and also as a way of establishing supportive relationships. The discourse of organizational culture was adopted by the UK public sector, education and health in particular, in the 1990s. Inquiries into large-scale failures in NHS care pointed to cultural factors such as poor relationships and disruptive behaviour between staff contributing to disastrous outcomes for patients and their relatives (The Bristol Royal Infirmary Inquiry, 2001, The Royal Liverpool Children's Inquiry, 2001, Davie, 1993).

Organizational researchers tend to conceptualize culture in two distinct ways (Smircich, 1983). Firstly, as a variable that can be taught or adapted to serve the purpose of an organization, linking to the scientific management tradition. Secondly, as a root metaphor that grows from human relationships and communication as a product of social processes in every layer of an organization, which is less available to managerial adaptation, linking to the anthropological tradition. Both concepts are often used in dynamic tension, because each lacks a key component of the other: the symbolic, affective component of the root metaphor, or the economic, material



component of culture as a variable (Alvesson, 2002). A third perspective is the concept of culture as fragmentation encompassing a multiplicity of views, subjective ambiguity and complexity:

*‘A web of individuals, sporadically and loosely connected by their changing positions on a variety of issues. Their involvement, their subcultural identities, and their individual self-definitions fluctuate, depending on which issues are activated at a given moment.’* (Martin, 1992, p153)

As the concept of organization began to move from monolithic entity to looser, and more fluid constructs in the 1990s, various aspects of organizational culture became a subject for research (Bolon and Bolon, 1996). A range of cultural aspects inform NHS organizational cultures, such as ethnicity, class, occupation, technology, division, specialism, gender, secondary groups, primary groups and leadership (Scott et al, 2003). Team cultures may diverge or converge with an organizational culture, they may support or be resistant to change, and collaborate or compete with each other. The NHS is particularly tribal in its professional groups (Mannion et al, 2008), which provides a challenge to creating organizational cultures that privilege interprofessional teamwork. Providing a Canadian perspective, Reeves et al (2010) found that UK teamwork and collaboration studies highlighted interprofessional conflict as a barrier but found little empirical research on resolving interprofessional tension and conflict.

Given the lack of conceptual clarity about what is meant by culture or culture change in the NHS, I take a socio-psychological position, which is situated in the anthropological tradition of culture as a root metaphor. In seeking to understand the culture of a particular clinical team in context, I chose to use the following definition of culture, which includes the conscious and unconscious group process by which team communication patterns are created and socially normalized:

*“a pattern of basic assumptions, invented, discovered, or developed by a given group, as it learns to cope with its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore is to be taught to new members as the correct way to perceive, think, and feel in relation to those problems.”* (Schein, 1991, p111)

I agree with the Foucauldian proposition that:

*“Understanding organizational culture involves an exploration of power relations to explain how individuals and groups create and contest meaning and how they use the resources to which they have access, including inter-professional teams, to advance their particular viewpoints and agendas.”*  
(Reeves et al, 2010, p73)

### **Concepts of team, teamwork and team effectiveness**

Alongside culture, the concepts of team and teamwork appear routinely in healthcare policy, conveying a normative view of these organizational forms, and an assumption that they are positive and beneficial to staff and patients (Finn et al, 2010), for example:

*“Healthcare is delivered by a team. The team includes clinicians, managerial staff and those in supporting roles. All members of the team are valued. The sense of a shared endeavour – that all of us matter and stand together – was crucial in the inception of the NHS.”* (Darzi, 2008, p59)

As with the concept of culture, team and teamwork is generally under-specified in policy and research. The use of the term “team” is commonly used to denote any staff group in healthcare. At its simplest, a team is defined as a group of two or more people working interdependently towards a shared goal, such as an aspect of patient care, that requires co-ordination of effort and resources (Salas et al, 1992). Teamwork refers to the behaviours, attitudes and cognitive processes that make interdependent performance possible (Salas et al, 2008). Teamwork and collaboration are often used interchangeably. However, I believe that collaboration is a social process that contributes to experiences of teamwork. I understand teamwork as a complex socio-psychological phenomenon that emerges in context and which is open to subjective interpretation and negotiation (Finn et al, 2010b). The cultural norms of a team will therefore influence how teamwork is experienced and reproduced.

Bamford and Griffin (2008) identified that teams and teamwork can be perceived as a facet of managerialism that requires individuals to subjugate their individual social and professional identity and interests to a collective team identity, which is aligned to organizational objectives and imperatives. Teamwork is therefore an identity discourse, which can be used by those with managerial authority to oppress

individual or divergent views as “resistant”, or to justify particular professional positions or attitudes (Finn et al, 2010). A number of studies of teamwork in healthcare have identified that those with senior roles in hierarchy describe their experience of teamwork more positively than those with less positional authority (Sexton et al, 2000, Makary et al, 2006, Finn et al, 2010).

Research in healthcare has focused on the characteristics, components or dimensions of effective teamworking and methods of measuring these (Buljac Samardzic et al, 2010). Technical-instrumental approaches have been prioritized, rather than socio-psychological approaches even though poor team communication and collaboration are widely cited as key to failures in healthcare (Lingard et al, 2004, Bleakley et al, 2006, Rosen and Provonost, 2013). Research into attitudes to error and teamwork in operating theatres and intensive care found that half the clinical staff surveyed reported that they found it difficult to discuss mistakes, and that differing perceptions of teamwork created barriers to discussing errors (Sexton et al, 2000). The Department of Health funded a major research project (1997-1999) to examine whether and how multidisciplinary teamwork in the NHS affected quality, efficiency and innovation. The project involved 400 teams across different sectors of the NHS (Borrill et al, 2001) and found that clarity of objectives, participation levels, commitment levels and support for innovation were related to team effectiveness across all health sectors. In continuing this strand of NHS research, Michael West and colleagues found a link between effective teamwork and reduced patient mortality:

*“where 60 percent of staff work in teams, their organizations had significantly better outcomes for patient mortality....25 percent more staff working in teams would be associated with 7 per cent reduction in deaths”* (West et al, 2002, p9)

Generally conceptual models of teamwork are linear, drawing on the socio-technical tradition of the input-process-output framework (Guzzo and Shea, 1992, Hackman, 1983), which aligns with the concept of culture as a variable. Models of teamwork in healthcare tend to follow in this tradition (Salas et al, 2008, Weaver et al, 2013). More recently teams have begun to be conceptualized as dynamic adaptive systems in context, aligning with Schein’s (1991) definition of culture, rather than static task focused entities (Arrow et al, 2000). The function of socio-psychological aspects of teamwork has been subject to conceptual debate and increasingly complex formulations by teamwork theorists since 2000. There is increasing support for the

proposition that teamwork emerges in context and that emergent states of a team play a critical role in determining the functional performative processes carried out (Marks et al, 2001, Ilgen et al, 2006, Burke et al, 2006, Weaver et al, 2013).

Marks et al (2001) define emergent states as:

*“constructs that are typically dynamic in nature and vary as a function of team context, inputs, processes and outcomes”* (Marks et al, 2001, p357).

Emergent states describe cognitive, motivational and affective states of teams produced by experiences of team processes that then become new inputs to subsequent processes and outcomes. Emergent states are fluid and easily influenced by context and different phases of teamwork. Similarly, Ilgen et al (2006) have argued that cognitive and emotional states created over time affect whether and how inputs get turned into outputs. They incorporate the notion of interplay and feedback loops to provide a dynamic view of teamwork.

Intrapersonal and interpersonal processes, such as conflict management, emotional regulation, motivation, morale and belief in the team, underpin the functional performative aspects of teamwork. Michael West (1996) introduced the concept of team reflexivity as central to effective teamwork. I would argue that team reflexivity is an emergent state, which involves:

*‘questioning, planning, exploratory learning, analysis, diverse explorations . . . learning at a meta level, reviewing past events with self-awareness, digestion, and coming to terms over time with a new awareness’* (West, 1996, p560).

Few models of teamwork include its temporal aspect. Marks et al (2001) argue that team processes are episodic and that they change as the team moves between action and transition phases and that particular team processes are more salient according to the phase. During transition phases teams are involved in planning or evaluating activity, rather than action phases in which the team conducts activity directly related to goal accomplishment. Edmondson (1999) found that most research into teamwork did not examine the social or learning behaviour of teams in her research into psychological safety and learning behaviour in work teams. Burke et al (2006) identify psychological safety as a critical emergent phenomenon in enabling team learning. Multiple feedback loops contribute to team evolution over time (Burke et al, 2006, Weaver et al, 2013).

This is particularly relevant to frontline clinical teams in healthcare, as most team development methods are focused on improving teamwork in the action phase where single loop learning occurs, and far less attention is paid to the transition phase where double loop learning (Argyris and Schon, 1978) occurs through seeking feedback, asking for help, sharing errors, improving collective understanding of the task or team processes and experimentation. I agree with Marks et al (2001):

*“The idea that teams perform in recurring action and transition phases and that they use different processes during different points in time challenges the way we have been thinking about team effectiveness....we believe that researchers and practitioners should consider a team’s temporal rhythms in measurements and evaluations of team processes and effectiveness.” (p369)*

### **Research into interventions that promote team effectiveness in healthcare**

Team performance and team effectiveness are often used interchangeably (Weaver et al, 2013). In my view the former refers to observable functional outcomes, and the latter encompasses a more subjective and multi-layered evaluative concept. Team effectiveness is socially constructed and shaped by contextual, organizational and systemic factors (Finn et al, 2010b, Weaver et al, 2013). A recent literature review of studies into interventions to promote team effectiveness in healthcare found a patchy landscape (Buljac-Samardzic et al, 2010). The review found that most studies were carried out with multidisciplinary teams in acute care and identified three categories of intervention: training; tools such as checklists and goal sheets; and organizational such as quality improvement programmes. Only three of the 48 articles identified had a specific focus on teambuilding although teambuilding was a by-product of other forms of team training such as simulation training based on Crew Resource Management in aviation. A number of recent literature reviews have found a lack of research into the assessment, development, and maintenance of interprofessional teamwork, in particular in-depth qualitative studies (Xyrichis and Lowton, 2008, Reeves et al, 2010, Ezziene et al, 2012). Whilst there are many accounts of interprofessional teamwork, they rarely draw on theory and tend to be uncritical and descriptive (Reeves et al 2010). There are few rich accounts informed by careful observations of actual practice. Buljac-Samardzic et al (2010) found that most intervention studies provided little information about the context of the intervention, which made it difficult to determine if the intervention would be effective in other settings.

In their case study of operational teamwork in an NHS teaching hospital, Bamford and Griffin (2008) found that there was limited evidence of multidisciplinary teamwork as defined by Borrill et al (2001) or of organizational support for teamworking. They suggest that teamwork is a paradigm that is useful for assessing how effectively groups and individuals work together rather than a specific organizational form. Bamford and Griffin (2008) make a conceptual contribution to the literature by proposing a range of organizational support required for operational teamwork to occur such as clear performance standards, frameworks and feedback, individual and team accountability, and empowerment.

In their integrated model of team effectiveness for patient safety in healthcare, Weaver et al (2013) identify “a constellation of factors that create the context in which teamwork occurs” (p11) at macro, meso and micro levels. The model moves away from a linear notion of inputs, to a more networked understanding of contextual influences on teams. Organization and team culture are included as key to the attitude of the team, in particular towards patient safety and the degree to which patient safety will be reinforced, such as support when speaking up about concerns. It is therefore closely linked to team psychological safety, which can be defined as “a shared belief that the team is safe for interpersonal risk taking” (Edmondson, 1999, p354). Intra-team processes are identified as communication, co-ordination, co-operation, coaching and adaptability. Emergent states that support or hinder these processes are identified as cognition, cohesion, collective efficacy, collective identity, mutual trust and psychological safety. The model also includes notions of collaborative sense-making and entrainment: the embedding of normative interaction patterns or habits within teams that are difficult to change. Finn et al (2010b) highlight the importance of taking a historical perspective in understanding the relationship between teamwork and its context, and the macro and micro-contextual factors that facilitate new forms of teamwork.

Weaver et al (2013) recommend that future research in healthcare should examine network features both within and between teams, as most research has approached teamwork using a linear framework. Such examination of networks would also throw light on the formation and impact of subgroups and faultlines within and between teams. For example, gender or professional identity can lead to faultlines in teams that may be dormant and activated by certain experiences. When faultlines are activated they create interpersonal conflict, coalitions form and affect morale and performance (Jehn et al, 2010). Weaver et al (2013) also call for empirical studies to

investigate the role of culture and climate in sharing the teamwork processes underlying safe care. This echoes Amy Edmondson's mixed methods research which included clinical teams as well as teams in other workplaces:

*"team psychological safety involves but goes beyond interpersonal trust: it describes a team climate characterized by interpersonal trust and mutual respect in which people are comfortable being themselves". (Edmondson, 1999, p354)*

### **Socio-psychological research and theory of group dynamics**

Most research and theory development about teamwork in healthcare is focused on producing generalized models of elements that produce team effectiveness. However there is little published evidence on interventions that develop positive team relationships and a supportive team culture from a historical position of low morale and fragmented relationships. There is an underlying assumption inherent in most teamwork and team development methods that team ineffectiveness is due to an absence of the elements that would make it effective either functionally or socially. However, psychoanalytic and socio-psychological research and theory into groups and group development suggests that collective defensive intrapersonal and interpersonal processes can lead to self-defeating and ineffective teamwork.

The accepted view of teamwork in healthcare as an egalitarian construct is appealing but overlooks the potential dangers of social groups (Bamford and Griffin, 2008, Edmondson, 1999). In his pioneering study, Janis (1972) developed a theory of groupthink whereby:

*"the term refers to a deterioration in mental efficiency, reality testing and moral judgments as a result of group pressures." (Janis, 1972, p43)*

Turner and Pratkanis (1998) studied social identity and groupthink and defined groupthink as a *"collective effort directed at warding off potentially negative views of the group."* Recent research into the socio-psychological processes that undermine moral behaviour has identified that social conformity, in group/out group social categorization, diffusion of responsibility to the group, roles and goals can *"facilitate neglect of the moral content of our decisions"* (Moore and Gino, 2013, p56). Social processes, such as social comparison, seeking self-verification, organizational



identification, group loyalty and euphemistic framing, also allow moral justification of immoral acts. Bureaucracy, anonymity and hierarchy are organizational contributors to moral inaction. Moore and Gino (2013) argue that social science has been better at identifying the causes of immoral behaviour than creating and testing methods for correcting it. In particular they suggest that future research focus on interventions that support individuals to expand their circle of moral regard because:

*“If dehumanization is a negative consequence of social categorization then expanding one’s circle of moral regard (Laham 2009) and practicing other-focused positive emotions (Algoe & Haidt 2009; Haidt 200, 2003a; Haidt et al 2001) may help reverse this outcome.”* (Moore and Gino, 2013, p70)

The socio-psychological aspect of teamwork has a rich theoretical tradition in psychoanalytic literature. In the 1950s and 1960s, Wilfred Bion (1961) developed his research and theory on the defensive social processes of groups, in which he argued that groups of people develop basic assumptions about reality as unconscious defenses against intolerable emotions and internal conflict. Basic assumption modes impede a group’s ability to grapple with their primary work task. Bion identified three basic assumptions (Stokes, 1994):

- *Basic assumption dependency* whereby the group behaves as if its primary task is to provide for the satisfaction and wishes of its members. The leader is expected to provide for and to protect the group, and not confront them with the real demands of their group purpose;
- *Basic assumption fight-flight* in which there is a perceived danger or enemy to attack or from which to flee. The leader is expected to devise an appropriate action and the group members believe that they must only follow;
- *Basic assumption pairing* which is based on the belief that whatever the problems and needs of the group, a future event will magically resolve these. The group behaves as if a pairing between two of its members, or of the leader and someone external will provide the solution.

In the same era, Menzies’ (1960) studied nursing in a general hospital and, using Freudian and Kleinian theory, found that a variety of social mechanisms were used as a defense against the anxiety and uncertainty of working with patients.

There is a similarity in many of Menzies’ themes with the work of Moore and Gino (2013) such as depersonalization, categorization and denial of the significance of the



individual, detachment and denial of feelings, the attempt to eliminate decisions by ritual task performance, and collusive social redistribution of responsibility and irresponsibility. There are also links to Bion's concept of basic assumption dependency, in her identification of the reduction of the impact of responsibility by delegation to superiors. The psychoanalytic tradition has been continued by the case study research of the Tavistock Institute, in particular Obholzer and Zagier Roberts' (1994) collection of papers about individual and organizational stress in the human services and Huffington et al's (2004) papers of working with the emotional life of organizations. Aside from these examples, psychoanalytic theory has been used rarely in research into team development generally, and in healthcare in particular.

In the practice development context, Holman and Jackson (2001) and Van der Walt and Swartz (2002) both used psychoanalytic theory to explain resistance to changes in nursing practice in frontline practice settings. Both papers evaluate why practice change programmes had been unsuccessful, despite clear acceptance that the principles behind the change were valid by the staff involved and initial displays of enthusiasm. Both recommend that development interventions with clinical teams take account of the natural defensive processes, which are evoked by anxiety about changes to working practices in healthcare. Holman and Jackson recommend:

*“that subsequent project designs should consider the unconscious agenda as well as the stated education aims. Structures need to be in place to contain the powerful emotions provoked by the activities of project work. In addition evaluation techniques need to be sophisticated in order to detect changes in practice that participants may not immediately recognize.”* (Holman and Jackson, 2001, p102)

Perhaps it is an unwillingness to grapple with the discomfort of change programmes and interventions not working in line with their espoused objectives that prevents wider exploration of resistance to change in healthcare settings. Such a view conflicts with the prevailing discourse that teamwork is positive and the socio-technical tradition which promotes task and work design as the key to improved team social and functional outcomes.

This project drew on psychoanalytic theory in general, and Bion's theory of group dynamics in particular, to develop a micro-level practice theory derived from specific

phenomena in context. The project sought to address a perceived gap (Reeves et al 2010) in providing a data-driven study of an interprofessional team development intervention using qualitative methods to produce a rich and detailed account of observed practice.

### **Relationships, communication and conflict in NHS teams**

Social relations in teamwork and associated issues of power, conflict and resistance are key because roles and status need continual negotiation (Finn et al, 2010). Lingard et al's (2004) observation study of communication failure in an operating theatre found that communication failure is part of a wider system of processes and relations and that the precise relationship between team communication and health outcomes required continuing research. Obholzer and Zagier Robers (1994) argue that troubled teams and individuals should be seen as symptomatic of wider organizational problems to be contained and understood in all their complexity. In my view, to focus on failures in team relationships as the source of team difficulties is a form of scapegoating and fails to examine the complexity of team socio-psychological processes.

Finn et al (2010) analyzed two separate ethnographic studies, which demonstrated how two different professional groups in healthcare (a medical records department and a surgical operating department) used the discourse of teamwork. Like Jones and Jones (2011), their findings question simplistic assumptions often made about teamwork. In both settings, teamwork did not play out in the way that policy and managerial texts would suggest. The study found that the group of record keeping clerks scarcely used teamwork as a discursive resource, despite it being routinely used by their managers and organizationally, and when teamwork was mentioned it was done so ironically or sarcastically. The record-keeping clerks used their social lives and personal problems as an alternative collective discourse and used this to construct an entirely separate and alternative collective identity signaled by the term "*the girls*".

The study of the surgical operating department (Finn, 2008) found that different professional groups used the ambiguity of teamwork discourse to reproduce their positions in different ways: surgeons and anaesthetists used technical and instrumental versions of teamwork, whereas nurses and ODPs employed a relational version of teamwork. All staff used the positivity of unity and goodwill towards colleagues associated with teamwork, whilst simultaneously employing the ambiguity

of teamwork to propose their own interpretation of its moral content. In both cases, teamwork discourses resulted in the opposite to the espoused effects of open communication and shared decision making, belonging and flattened hierarchy, reproducing traditional professional positions in one case, and entirely excluding a group of staff from participation in the other. In constituting problems in terms of teamwork, a managerial discourse is legitimized and other organizational or social structural factors (such as identified by Bamford and Griffin, 2008) do not need to be considered.

Makary et al (2006) found similar discrepancies in surgeons', anaesthetists' and nurses' perceptions of teamwork. In their study medical staff were likely to rate teamwork as good and nurses rate the same teamwork experience as poor. Makary et al (2006) propose that long-standing differences between medical and nursing professionals such as status, authority, gender, ethnicity and patient-care responsibilities contribute to this discrepancy. They also contribute an insight from discussions in the survey feedback meetings that nurses described collaboration as having their input respected, and medical staff described collaboration as having their needs anticipated and instructions followed by nursing colleagues. This suggests a leadership-followership dynamic with different expectations of collaboration.

Leadership is often included as a key dimension of effective teamwork, but there has been less attention paid to the followership dimension (Ezziane et al, 2012). Recent theories of followership in healthcare (Grint and Holt, 2011) elucidate different modes of followership in relation to leadership. The existence of dynamic environments and hierarchy has been shown to create barriers to active and responsible followership in a number of studies (Ezziane et al, 2012). Drawing on Grint and Holt's (2011) typology of followership in the NHS, there is a need for research into the creation of adaptive leadership-responsible followership relationships in teams in view of increasing uncertainty and complexity of healthcare work. In a radical departure from most teamwork theory, Engestrom et al (1999) argue that concepts of stable teamwork and team identity are not applicable to acute healthcare settings. They conceptualize professional collaboration in acute healthcare as "*knotworking*", arising from complexity and fluidity of the settings in which professionals tie, untie and retie strands of activities with different professionals in short-lived episodes.

### **Evaluations of interventions to improve team culture in healthcare**

In response to the absence of qualitative research into the development of interprofessional teamwork, Jones and Jones (2011) undertook an ethnographic study of a twelve-month interprofessional teamworking initiative on a ward in a UK teaching hospital. The service improvement programme had been initiated by an interprofessional group of staff in response to ward staff concerns that a lack of teamworking was having a negative impact on patient safety. The study evaluated how teamwork practices had changed as a result of the initiative and how the processes used affected teamwork from the staff's perspective. They found that rapport and positive working within team meetings had led to better teamwork and that collegial trust was essential to a productive and safe working environment. Management of conflict was easier when the team was working towards shared interprofessional objectives allied to a greater focus on the patient. They note that trust was not a fragile commodity in the team but provided a moderating influence in conflict situations. High levels of professional autonomy led to more effective teamwork, professional satisfaction and lower sickness levels which proposes a different view to that of Bleakley et al (2006) who suggests that professional autonomy damages interprofessional teamwork. Providing a new insight to the existing literature, they found that:

*“teamworking in this setting was discussed by interviewees not as an abstract managerial construct but as an emotionalised and negotiated by-product of working closer as a group.”* (Jones and Jones, 2011, p180)

This insight illuminates the relational and cultural aspect of a clinical group process and supports the theoretical view that:

*“At the team level, culture can similarly be seen as the meanings and perceptions different team members attach to their team as well as their interprofessional interactions....attaining shared agreement is an on-going process.”* (Reeves et al, 2010, p73)

In my view, evaluating team members' meanings and perceptions is central to determining the success or “worth” of any team change initiative. The “*science of teams in healthcare*” (West and Lyubovnikova, 2012, p136), which seeks to define generalized task-oriented, technical and instrumental methods for improving teamwork overlooks the complexity and layers of teamwork as an emergent cultural

phenomenon. Most of the training methods associated with improving teamwork in healthcare are focused on improving patient safety, rather than teamwork as an end in itself (Buljac-Samardzic et al, 2010). This might suggest, like Jones and Jones' (2011) study, that teamwork is a byproduct of groups of interprofessional colleagues focusing on patient safety, rather than an end in itself.

My project was informed by recent emancipatory action research carried out in the field of practice development. Brown and McCormack (2011) explored the influence of the practice context on the realities of developing nursing practice. They found that three key themes (psychological safety, leadership, oppression) and four subthemes (power, horizontal violence, distorted perceptions, autonomy) influenced the way in which effective nursing practice was realized. These themes may not be particular to the nursing context and my research sought to identify if similar themes had influenced team development in a different clinical context and circumstance.

The theme of trust and psychological safety to allow the emotional experience of feeling close to colleagues, and therefore a "team" is present in other recent studies. Miller et al (2008) found that the suppression or ignoring of the emotion work of nurses and their esprit de corps, as well as corridor conflict with physicians prevented interprofessional collaboration. In another study, team effectiveness was found to improve when people felt emotionally secure with colleagues (McCallin and Bamford, 2007). Brown and McCormack (2011) found that the creation of a psychologically safe space through facilitated reflective sessions supported person-centred practice development in a complex clinical environment. They found that there were few studies that had explored in depth the practice context in order to improve the practice culture and that psychological safety had been given little attention in implementation literature. Miller et al (2008) found that few interprofessional initiatives addressed emotional dynamics.

There are similar themes in Hoyle's (2004) account of conflict resolution in a healthcare setting using a contextualized mediation process. Hoyle describes the creation of a psychologically safe space with the psychoanalytic concept of "containment", and a facilitative approach drawing on Schein's (1999) theory of process consultation. Both Hoyle (2004) and Brown and McCormack (2011) emphasize the importance of "context" in affecting practitioners' thoughts, feelings and actions, and in making the context explicit so that people become empowered. This research project sought to facilitate awareness of the emotional interaction

between context and practitioners by creating a psychologically safe methodology so that future situations could be negotiated by participants with an underlying experience of trust and mutual respect for each other:

*“The form that teamwork takes in any given context, therefore, is the outcome of these micro-political struggles. While the collaborative teamwork ideology is a potential form of social control, promoting cooperation and preventing conflict among disparate professionals (Opie, 1997), its inherent ambiguity as a ‘loose rubric for action’ (Griffiths, 1997) opens up space for the negotiation of working arrangements in the context of established authority relationships.” (Finn et al, 2010, p1149)*

Bleakley et al (2006) carried out a multifaceted longitudinal collaborative inquiry into a structured educational intervention to improve teamwork climate in an operating theatre in a large acute UK hospital. They found that using a collaborative inquiry method of evaluation established a self-sustaining and self-researching culture. In narrating an ethnographic case study of a large-scale culture change in an acute hospital, Bate (2004) makes a powerful argument for the use of stories to create a sense of community within a group that can facilitate culture change. He advises against interventions or projects that try to change culture directly arguing that culture emerges from the stories told.

### **Appreciative inquiry as a method of evaluation**

I have developed a particular interest in appreciative inquiry during this project (see also Chapter 3). Wright and Baker (2005) evaluated the effects of appreciative inquiry interviews on staff development with an NHS acute hospital paediatric ward. Teamwork was one of the widely endorsed themes that emerged from the appreciative inquiry interviews, suggesting that it is central to positive experiences of working in frontline healthcare. In follow up interviews two years after the intervention, several respondents cited improved communication with enhanced sense of belonging to the team and improved relationships with colleagues. They found evidence of second order learning (Argyris and Schon, 1978) suggesting that the focus of appreciative inquiry on their own achievements gave participants autonomy and confidence to stand out against the group when appropriate. They argue that appreciative inquiry allows managers and others intervening from outside a clinical microsystem to cease to see themselves as diagnosticians and problem

solvers, but as facilitators and part of the wider system, needing to develop their understanding, language, relationships and roles as much as any other participant.

The complexity of teamwork and how it is locally defined means that evaluating improvements in teamwork in a way that is meaningful to participants must involve participants in all elements of the inquiry. As stories are used for sense-making in organizations, then a change in the stories that are told changes the inner dialogue of the organization (Bate, 2004, Bushe and Kassam, 2005). Bushe and Kassam (2005) reviewed the published literature on the transformational use of appreciative inquiry as an approach to organization development. They suggest that a change in the macro-narrative of an organization can occur through changes in many micro-narratives. In the case studies where there was evidence of transformation all created new knowledge, created a generative metaphor, penetrated the ground of the organization, and all but one used an improvisational focus to the changes enacted. These characteristics were in a small minority of the non-transformational cases as well. Appreciative inquiry has been used both as an organization development intervention and as a collaborative method of formative evaluation, which has been found to enhance participants' ownership of and commitment to future monitoring and evaluation practices (Coghlan et al, 2003).

### **Realist evaluation of interventions in NHS clinical settings**

The project drew on Boomer and McCormack's (2010) evaluation methodology, which aimed to determine the "worth" of an emancipatory practice development programme. This can be linked to realist evaluation as described by Fox et al (2007):

*"realist evaluation is always formative rather than summative. The purpose of the evaluation is to help develop the effectiveness of a programme by understanding the factors that make it effective."* (p72)

Realist evaluation is a theory driven approach to evaluating complex social and healthcare interventions (Rycroft-Malone et al, 2011, Cheyne et al, 2013) between patients and healthcare practitioners, and local and large-scale service changes. It offers an opportunity to evaluate innovative practice, refine existing theory and methods of intervening in complex situations (Wand, White and Patching, 2010). Evaluation is increasingly used for accountability or judgment purposes rather than its additional functions of creating new knowledge and improving practice (Cooper, 2014). Realist evaluation focuses on learning about the contexts that allow

interventions to be taken up (Rycroft-Malone et al, 2011). Research into teamwork in healthcare has focused more on generating theory rather than understanding the implementation of team development in practice. Realist evaluation offers the opportunity to address a gap in the literature about how team development interventions are received by participants and impact on their practice, as interventions work when the resources on offer strike a chord with participants and social changes occur (Wand, White and Patching, 2010). It is particularly suitable to the areas I have identified as missing in current accounts of team development in that it engages with the processual and contextual nature of knowledge use over time. Little research exists in relation to implementation over time within sustained organizational initiatives (Rycroft-Malone et al, 2011).

## **Summary**

My review of the literature suggests that the lack of conceptual agreement about culture and culture change, teams and teamwork is at odds with the normative usage of the terms in healthcare policy and organizational discourses. Recent qualitative studies have demonstrated that this looseness and ambiguity of terminology serves multiple and often conflicting purposes in the macro, meso and micro-contexts of the NHS. The functional and social aspects of teams are often confounded, and the relationship between these aspects is still open to debate. Team development in healthcare is generally focused on tools and training to improve functional skills rather than social relationships. Where social elements are included in team training programmes, these tend to be taught through socio-technical elements such as specific communication tools. The temporal and contextual enactment of teamwork has received little attention in theoretical and practice literature. Recent studies have highlighted the importance of the practice context in supporting or preventing nursing practice development.

Disruptive behaviour in teams has been shown to have detrimental effects on team morale, functioning and patient outcomes. There is evidence that group defensive patterns of relating have negative effects on the moral content of decisions and actions (Gino and Moore, 2013). Within the psychoanalytic literature, there are case studies of socio-psychological interventions to improve defensive group communication patterns and relationships. These have been used to inform practice development studies of failed socio-technical development initiatives. Recent ethnographic studies of interprofessional teamwork have offered new and surprising insights into how collective identity is formed and experienced by healthcare staff,



challenging both normative discourses and theoretical models of teamwork. There are few qualitative studies of team culture change interventions. This suggests that the chosen topic for this evaluation is ripe for theoretical and practical exploration.

Themes of trust and psychological safety as a precursor to and outcome of team learning recur throughout various socio-technical and socio-psychological studies of teams. This suggests that team development interventions and their evaluation require methodological approaches that develop trust and psychological safety such as collaborative approaches to inquiry and the use of stories to create community. The collaborative approach of appreciative inquiry has been found to evoke sustained positive experiences of teamwork and improved relationships for an acute paediatric ward in the NHS (Wright and Baker, 2005), and, in some cases, to generate transformational group learning in other organizational contexts (Bushe and Kassam, 2005). Appreciative inquiry has been used both for team development and evaluation purposes in a number of studies.

Realist evaluation is suited to studying change interventions over time in complex and dynamic healthcare settings. Recent realist evaluation studies have refined theory and informed practice in the light of data gathered from practice in context. This case study responds to recent calls for in-depth qualitative evaluation of healthcare team development interventions in seeking to understand what worked, or did not work, for whom, in what circumstances and how.

Key themes emerging from the literature review for the project were:

- little had been written about the practice of working closely with ineffective teams to develop effective teamworking, therefore this was innovative practitioner research;
- I sought to illuminate the lived experience of an organization development intervention designed to improve team culture so that it would be better understood by myself and others practising in this field;
- teamwork is an emergent social phenomenon that is sensitive to time and context and the methods chosen reflected this understanding;

- in my view the social and psychological processes of a team in response to macro, meso and micro-contexts produce the team culture; therefore, a team's culture changes in response to changes in context and the social and psychological processes of the team;
- I chose to use a collaborative approach to evaluation based on the philosophy and methods of appreciative inquiry in order to transform the defensive routines of the team into more active and constructive dialogue and interaction;
- the central importance of creating psychological safety through the evaluation in order to promote social and learning behaviour for me and participants;
- use of a realist evaluation framework for writing up the project in order to develop theory and inform future practice.

In conclusion, whilst much has been written about team effectiveness, its importance to staff and patient well-being in the NHS, and also about the reasons for and problems associated with dysfunctional teams, the novelty of my project was to focus on working closely with a team in distress. My aim was to get beneath the surface in order to explore the anxieties, tensions, perceptions and possible issues around hegemony of a specialist clinical team. Undertaking the study has helped me to understand and improve my practice and has the potential to contribute new knowledge to the wider theoretical and practice debates outlined in this chapter.

### **Chapter Three: Figure of eight knot – a useful climbing knot as you can see at a glance if it is tied correctly - design and methodology**

*“...the practices of researchers within the field – the ways they present themselves, collect data, write notes, analyse – will be fashioned both by their particular disciplinary interests and by themselves as people.” (Mulhall, 2003, p310)*

In this chapter, I introduce and describe my ontological and epistemological positions to investigating the research questions posed in the previous chapter. The insider nature of the research and implications for the design and methods is explored and reflected on throughout the chapter and in particular reflexivity and ethics within the research process.

#### **Research paradigm**

Writers on practitioner research have called into question the relevance and fit of traditional scientific paradigms (Reed and Procter, 1995, Robson, 2002, Fox et al, 2007, Costley et al, 2010). Reed and Procter (1995) argue that both natural and social scientific paradigms aim to ensure that researcher bias is removed from the research so that it can become “value free”. I share their view that practitioner research is necessarily value bound and often seeks to test assumptions about what is “good” or to improve practice. Therefore the researcher’s stance and assumptions about what is defined as “good” or “improvement” are explicit and legitimate elements of the research. Practitioner researchers cannot simply adopt the research methods of conventional social science (Robson, 2002); a practitioner research paradigm requires a separate working through.

I agree with the view that polarization in paradigm debates is unhelpful (Robson, 2002, Silverman, 2010) and have found the following integrative approach helpful:

*“the main point is that your paradigmatic approach needs to reflect your genuine belief and it needs to be coherent.” (Costley et al, 2010, p85)*

The guidance of the Medical Research Council for developing and evaluating complex interventions (2012) has led me to consider the choices that researchers make between competing demands and that *“‘best available methods’, even if they are not theoretically optimum may yield useful results” (p8)*. Its advice to acknowledge limitations and trade-offs made in the course of the research is

particularly relevant to practitioner research. Costley et al (2010) make a paradigmatic distinction between practitioner values and perspectives, which can change rapidly as a result of gaining new knowledge or understanding and accommodating different viewpoints; and “*deep-rooted values*” (p86) that change slowly and subject to deep reflection. I understand these deep-rooted values to be the cornerstone of professional practice (Reed and Procter, 1995). Reading texts on contemporary approaches to practitioner research throughout this doctoral journey has caused me to reflect, think about and surface my deep-rooted values.

### **Ontology**

The project was concerned with investigating the social world and my ontological position sits within the critical research paradigm (Locke et al, 2010, Costley et al, 2010, Rolfe, 2011). I believe that social reality is politically bound and continually recreated in the moment of interaction between individuals, their history and their context (Fox et al, 2007). Crotty (1998) describes this as social constructionism, whereby people shape and are shaped by the cultures they inhabit. As a critical researcher I view social reality as subject to power dynamics that cannot be rendered value-free or fixed to a single perspective (Holloway & Wheeler, 2010, Costley et al, 2010). Social reality is a collaborative, fluid construct, and the methodologies associated with critical research reflect this. As a critical practitioner researcher I wanted to recognize and work democratically in relation to the politics and power relations in my organization and the wider NHS.

I have been influenced by the philosophy of critical realism as originally proposed by Roy Bhaskar and cited in a range of recent healthcare programme evaluation research (Wand, White and Patching, 2010, Rycroft-Malone et al, 2011, Williams et al, 2013). Critical realism proposes that there are many layers to the social world and causal mechanisms operate at different layers of reality. “Generative mechanisms” refer to the underlying structures, powers and relations that operate beneath the surface of observable reality to produce effects in particular contexts. These generative mechanisms can only be known through an interpretation of their observed effects, or outcomes.

### **Epistemology**

Critical research takes the position that knowledge is both a source of power and a product of it, and provides an opportunity to improve social and political mechanisms. Knowledge is ambiguous, cannot be fixed to a single account and is always

provisional. From a critical realist position, there is interplay between social structures and human agency such that each can limit or transform the other. This offers an opportunity for people to identify, critique and challenge sources of oppression in social structures. Therefore knowledge can either empower or disempower people, as described by Foucault's work on discourses of power (Grbich, 2007). It cannot be rendered neutral and descriptive by methodology and reflexivity. Critical research aims to understand and critique power in society (Freshwater, 2011).

A central concern of critical researchers is the emancipation of oppressed people. Unlike interpretive research, the critical researcher does not seek to give voice to participants' views to create understanding but aims for them to voice and take action themselves (Boomer and McCormack, 2010). My project design sought to collaboratively research aspects of the shadow organization, its hidden culture and values (Huffington et al, 2005; Fox et al, 2007) and to identify both internalized and external sources of oppressive cultural practice, in order to create a more self-aware and empowered workplace culture.

In my view, the moral positioning of the critical paradigm fits with practitioner research. Both seek to improve practice and identify what is "good". Emancipatory Practice Development, a strand of current nursing research that operates within the critical research paradigm, has influenced my epistemological stance (Manley and McCormack, 2004). Boomer and McCormack (2010) argue that practice improvement and sustainable culture change are most likely to be achieved through the fostering of critical awareness in participants. The influence of Paulo Freire's work on "conscientisation" in the 1960's can be seen in this view (Crotty, 1998), as well as Mezirow's (1991) theory that critical reflection leads to a shift in beliefs and attitudes in adult learner, which underpins changes in action.

My epistemological view is also informed by a psychodynamic position that emotions are a source of rich insight into unconscious processes that affect individual and group behaviour. In particular, I am influenced by the work of Bion (1968), Menzies (1960) and the Tavistock Institute of Human Relations (Obholzer et al 2005), which suggest that groups generate unconscious defensive strategies to cope with the stresses of the workplace, particularly in healthcare. Containing and working through these defensive group processes so that unmet emotional needs of staff for

belonging, trust and understanding can be surfaced and understood is key to my psychodynamically informed epistemological position.

### **Reflexivity, relationality and reciprocity**

Reflexivity is central to critical research as it aims to generate multiple discourses. It invites debate and demands that the researcher is self-critical and open to feedback during the research process, particularly around issues of power and politics. Reflexivity allows the researcher to consider and articulate their impact on the research. I would argue that the use of methodology and reflexivity creates the difference between qualitative research approaches and descriptive writing such as journalism, by articulating the structure and systems used by the researcher to construct their account. The researcher is the main research tool (Costley et al, 2010; Holloway & Wheeler, 2010) and reflexivity is vital to ensure appropriate self-management.

As an insider practitioner researcher, my research provided an opportunity to learn about my professional and personal self (Costley et al, 2010) and the relevance of one to the other. A reflexive approach is central to professional practitioner development (Schon, 1983, Teekman, 2000, Rolfe, 2011) as it creates tacit knowledge through informal learning (Eraut, 2004). By using methods to encourage a reflexive process, both in my own development as a practitioner researcher and within the project's realist evaluation process with participants, I aimed to generate data of organizational learning that is generally hidden from view, and therefore hidden from understanding.

I expected to enter and alter the reality that I was researching. In order for the research to be useful to other people, I have sought to describe my experience of the research process and outcomes honestly and accessibly so that the reader can determine my impact on the research and whether its findings are relevant to their own professional perspective and context. Reflexivity ensures that the researcher considers the ethical, political and moral dimensions of the decisions that she takes in the course of the research (Costley et al, 2010). Finlay 2002 (cited in Holloway and Wheeler, 2010, p9) identifies five types of reflexivity which were relevant and applied to this project:

- Introspection: exploration of my own experience and meaning as a source of insight and interpretation for the project;

- Intersubjective reflection: the relationships between myself and participants, and the relationships between them informed the research process;
- Mutual collaboration: participants' reflection on the research was influential and incorporated into the research design and account;
- Social critique: the social and political relationships between participants including me, and their impact on the project were explored and acknowledged;
- Discursive deconstruction: text used in the process of the project and in its report has multiple meanings, which were explored and acknowledged.

As a critical practitioner researcher studying my own workplace, the concept of relationality helped me to become increasingly aware of my professional, social and psychological position in relation to participants and my responsibility to share power with them about research decisions and actions (Vandenberg and Hall, 2011). I aimed to evaluate all claims to truth equally and to avoid reinforcing the dominant power relations at play by considering and discussing with participants the possible impact of the research process and outcomes on them. Through consulting and involving participants, I sought to build trust and rapport, defined by Vandenberg and Hall (2011) as reciprocity. I felt it was important to allow participants to participate or not in any aspect of the research without questioning them about their reasons, so that they could exercise social action according to their judgment and share their thoughts with me as they chose.

## **Research Design**

The research was designed to evaluate a preceding eighteen-month organization development intervention with a clinical team that had been identified as in difficulty, using a single in-depth case study as defined by Yin (2009):

*“A case study is an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident”* (Yin, 2009, p18).

I chose a realist evaluation design to identify what worked (or did not work) for whom under what circumstances and how in this particular organization development intervention (Pawson and Tilley, 1997). In realist evaluation, the relationship between context, mechanism and outcome is not viewed as fixed, or singular, but multiple and changing over time. It is:

*“reformist, with the basic goal of developing initiatives that help to solve social problems and inequalities.” (Wand, White and Patching, 2010, p231)*

Drawing on the critical realist philosophy of Roy Bhakshar, causality is not linear but generative, and realist evaluation aims to describe how opportunities and ideas introduced into appropriate contexts can produce successful outcomes (Cheyne et al, 2013). Theory is developed iteratively as emerging data is analyzed, and interpretations are explored with research participants, professional and academic peers. Realist evaluation *“seeks to penetrate beneath the observable inputs and outputs of an intervention”* (Wand, White and Patching, 2010, p235) to understand the generative mechanisms that lie beneath the actual and empirical worlds.

The project aimed to identify mechanisms that explained how the actions taken in a particular organization development intervention produced outcomes for different stakeholders in the particular context in which they work. The research was designed to evaluate the approach that I had developed with my organization development colleagues to intervene with teams in difficulty, and to recommend changes to improve our practice.

The methodology for the project was evolutionary responding to the emergent nature of the social world I was investigating (Wand, White and Patching, 2010) In the course of the evaluation I responded reflexively to the unfolding contexts, mechanisms and outcomes that I identified. The emergent design required me to remain open to the changing process of the project, which was non-linear and became increasingly self-organizing and complex (Suchman, 2010). There were three phases over a period of fifteen months with methodological developments in response to context changes and emergent realities as follows:

- Phase One: Gaining awareness of the context, mechanisms and outcomes of the organization development intervention from multiple viewpoints;
- Phase Two: Piloting an appreciative inquiry approach to evaluation;
- Phase Three: Discovering the team's positive core and refining theory about what works for whom, in what circumstances and how.

### **Description of organization development intervention prior to the research project**

In April 2010 the senior operational manager with responsibility for the frontline



clinical team described in Chapter One asked me to provide her and the team's clinical director with organization development advice and support. They were concerned by a recent deterioration in already fragmented relationships between senior members of the team, and by junior members' reported dissatisfaction with the way the team was working. Following a series of joint conversations with clinical and managerial members of the team we agreed with them that the team was "in difficulty". Within the organization's lexicon this means that the team's culture was causing concerns for patient safety and staff well-being and was a priority for an organization development intervention.

I led the organization development intervention from April 2010 until October 2011. My aim during this time was to facilitate an improvement in the team's culture using an emancipatory action research process (Fox et al, 2007, Boomer & McCormack, 2010, Brown & McCormack, 2011). Fox et al (2007) define its focus as that which is important to marginalized groups and seeking to bring about positive change with them. Brown and McCormack (2011) argue that it

*"best lends itself to the process of confronting unsatisfactory or distorted practices... by fostering a culture of critical intent through reflective discussion."* (Boomer and McCormack, 2011, p3)

I initiated collaborative Plan-Do-Study-Act (PDSA) cycles with the team, which aimed to pass complete ownership for team development gradually back to the team itself, and to build skills for self-sustaining team health in the future. PDSA cycles encouraged the team to participate in critical reflection about the team culture, and to evaluate their progress using both hard and soft data. Porters, administrators, allied health professionals, nursing staff, medical consultants, medical leaders, and senior managers were all stakeholders and participants in the process.

At the beginning of the intervention, I commissioned a series of confidential and anonymized individual semi-structured discovery interviews, which were carried out by an organization development practitioner from outside the Trust with all members of the team. The purpose of the interviews was to provide an opportunity for individuals to describe their experiences of the team culture. The organization development practitioner drew together the key themes and shared them with me and the team to support open and collective sense-making of the team's culture and to provide a platform for on-going improvement and evaluation. The thematic analysis of the interviews highlighted cultural problems similar to those reported

subsequently by The Mid Staffordshire NHS Foundation Trust Public Inquiry: “a culture of fear...a culture of secrecy...a culture of bullying” (2013, p8).

The intensity of external involvement in the team increased in June 2010 following a serious clinical incident. At this point, the team was designated in “special measures” by the Medical Director, a term originating in the education sector and more recently adopted by the NHS to denote a service that has serious and systemic failings and that leaders require intensive external support over a period of time to improve the service. In the Trust, teams in special measures generally receive 12-18 months of organization development support until quantitative and qualitative data suggest a sustained improvement in the team’s functioning. In this case, there was also a separate management investigation into the serious clinical incident after which the team’s long-serving manager retired.

The team and its external managers worked intensively to make a range of improvements identified as needed by team members in their discovery interviews. They collaborated on a restructure to create more leadership roles, reviewed and changed communication processes, and designated clear roles and responsibilities amongst the team. I held group and individual discussions about disruptive behaviours that had become normalized and team members took collective and individual responsibility for changing these. I also conducted three team-building workshops to encourage team members to share their vision and values for the team, and to seek to build trust, safety and support in their relationships. I provided coaching support to the external management team and frontline team leader throughout the intervention.

Key Performance Indicators, which were quantitative measures, indicated an improvement in efficiency and effectiveness by June 2011. I used the Aston Team Performance Inventory (West, Markiewicz, Dawson, 2009) to benchmark the staff’s experience of team processes and outputs, and to measure improvements. This was carried out in June 2010 and repeated in June 2011. It reported low levels on all dimensions in June 2010 with some improvement in June 2011, but still below the benchmarked norm. Informal feedback from different stakeholders gave a spectrum of views about improvements that individuals had experienced in the team’s culture ranging from no change at all to significant improvement. I noted that members of the team who held a senior position in the hierarchy were more likely to rate the intervention a success than those in a junior position. Consequently, I believed that it

was important to carry out a more in-depth qualitative evaluation, particularly with junior staff, that would inform any future development work with the department and also inform my organization development practice. My major doctoral research project afforded me this opportunity.

### **Legal, Ethical and Moral Considerations**

I sought ethical approval from the Research and Development Committee of the NHS Foundation Trust where I work. As this project met the criteria for a service evaluation, it did not require full committee approval, but review by two members. I discussed the project with my line manager, the senior operational manager and clinical director of the team involved. The approval letter is at Appendix 1.

Following approval from the Trust's Research and Development Committee, I applied for approval from Middlesex University HSSC Health Studies Ethics Sub-Committee under categories A2-6 which required completion of the proposal form, participant information sheet, consent form, letter of consent from the Trust plus evidence of permission to access data. I contracted about the objectives and use of the research explicitly in clear, plain English with participants at the beginning of each meeting, as well as in the participant information letter and consent form (attached at Appendix 2 with approval letter).

### **Confidentiality, Trustworthiness and Credibility**

I anonymized individual information as I collected it, using numbers to identify recordings and transcripts, which have been stored confidentially on a password protected computer. I have changed all names of participants to pseudonyms to protect their confidentiality and anonymity. I have ensured that the team and the Trust cannot be identified through information contained within this report.

I have sought to provide a credible and trustworthy piece of research by following Lincoln and Guba's (1985) recommendations for prolonged engagement with and persistent observation of the research context, and by challenging my own biases and assumptions through regular discussion with participants, peers, supervisors and academic advisers throughout the course of the research. I returned to participants about ideas and interpretation of data and to hear their perspectives on the data and methods as they evolved. I involved participants in creating and interpreting data collaboratively through the methods of appreciative inquiry and discovery and action dialogue. I used multiple data sources from different settings and methods over a

period of fifteen months to provide a rich, detailed and well-developed account of the research in order to present a deep understanding of the case.

### **Sensitivity of access**

As a practitioner researcher, I was aware that issues of reciprocity and allegiance (Reed & Procter, 1995) were vital to consider, particularly as there was a change of role that I negotiated part way through an extensive culture change programme where I had established relationships. I was mindful that my privileged position with this team allowed me access. The particularly difficult circumstances the team had experienced led me to adopt an open and collaborative approach that sought to explore and acknowledge the power dynamics as a legitimate area of concern.

My power and role in the organization development intervention created understandable distrust and anger towards me from several potential and actual participants at various times. When I proposed the doctoral evaluation project, there was hostility towards me from some potential participants expressed in active and passive ways, and voiced suspicion about possible uses of the project. I went to two team meetings to discuss the evaluation project with the team and emphasized that people could choose to participate or not. I stated my view that it might help the team to reflect on what had happened and to make sense of it in order to move forwards. The majority of team members chose to participate. However, the administrative and portering team members chose not to participate, so views from these professional groups were not represented in the evaluation.

The design was flexible and was re-negotiated with participants as it progressed, as their psychological ease was essential both for their well-being and the project outcomes. During the intervention prior to this project, at the team's request we agreed a change of format, time and focus for group work so that it would better facilitate our agreed objectives. My approach would continue to invite participants to "pull" the evaluation process into a shape that fitted their needs, rather than to "push" my beliefs about how it should occur (Sharp, 2005).

Participation was sought from all stakeholders involved in the organization development intervention and only those who gave their consent were included. All research participants had the right to withdraw at any stage. Confidentiality, individual anonymity, physical and psychological well-being were central to the project. I conducted the research with an ethic of care for participants and gratitude

for their involvement as proposed by Gibbs (2007). As a critical form of research it aimed to generate multiple discourses. I invited critical debate and was self-critical and open to critical feedback during the research process, particularly around issues of power and politics. I privileged “*knowledge exchange*” (Costley et al, 2010, p113), respect and gratitude, and gave equal weight to my knowledge and that of other participants.

Given that the project explicitly invited participants to understand and influence the shadow side of their culture, this was likely to make participants and other internal stakeholders, such as senior executives, anxious (Fox et al, 2007). All the Trust’s services were undergoing intense scrutiny to improve productivity and efficiency. Some services were being merged and/or reconfigured with staff redeployed. I was mindful that my research could be used to justify service changes either to the team involved, or to other teams. Alternatively it could be suppressed to allow changes to occur.

I recognize that the right to employee voice is a source of intrapersonal, interpersonal and organization struggle in a professional bureaucracy such as the NHS (Krefting and Powers, 1998). Forms of managerial control exert censor or invite self-censor of the voice of employees, particularly if the exercising of voice suggests a failure of management. As in all cases of complex long-term team conflict, organizational and managerial failures will have contributed to this team’s difficulties. Their exercising of voice drew attention to these failures, and the investigation and intervention were experienced as penalizing results. Organizational interventions often have more advantage for managers in terms of aligning employees with organizational norms than for employees who are notionally supported (Krefting and Powers, 1998). This alignment may exact a significant personal cost (Hochschild, 1983). I designed the project with a view to providing opportunities for participants to exercise voice in different ways. However, the preceding intervention will have predisposed team members to seeing me as a member of the managerial system, and may have compromised their choice either to participate, or conversely to refuse to participate. I addressed the power dynamics that emerged during the project by sharing with the team my own doubt and feelings of failure in relation to their situation and by influencing the managers involved to take an appreciative rather than problem-solving approach to their on-going relationship with the team. I believe that this contributed to an increasing willingness for participants to exercise their voice in a group situation as the project progressed.

I chose a realist evaluation research design to reduce the possibility of the project being used to disempower participants or other teams either in its process or outcomes. The aim was to evaluate what worked for, or did not work, for whom, in what circumstances and how (Pawson and Tilley, 1997) in the context of a team in difficulty, who had experienced a major critical clinical incident, using an appreciative framework that would value participants' experience and positive core. I briefed participants and other stakeholders regularly about progress and continually considered and incorporated the changing political context of the research into dialogue with participants, and other stakeholders.

The research findings have the potential to impact on the way that improvements in team culture are conceptualized, managed and evaluated in healthcare settings and to be of interest to a wider audience. I have a responsibility to healthcare teams in general to consider the reporting of the research in a way that is going to contribute constructively and with integrity to the development of team culture in healthcare. With this in mind, I consulted with my network of internal and external healthcare colleagues, and academic peers and supervisors in the writing up of my research.

I have also given ethical consideration to publishing information about the shadow side of my organization and whether this may cause reputational damage for the NHS. I would argue that owning and discussing the more difficult aspects of organizational life demonstrates a commitment to assuring integrity and probity and ensuring the best quality of care for patients.

## **Methods**

### **Sampling**

Purposive sampling was used as the stakeholders of the preceding organization development intervention were defined as both the object and subject of the evaluation. The aim was to include as many of the stakeholders as were willing to take part. This would allow for a complete and multi-layered picture to emerge of this particular case. I invited all stakeholders in the original team development intervention (n=23) to participate in the research project. These fell into distinct professional groups:

1. Medical consultants (n=3);
2. Nursing staff (n=3);

3. Allied health professionals (n=12)
4. Administrative staff (n=3)
5. Porter (n=1)
6. Manager situated outside the frontline team (n=1)

Invited participants were sent an information letter and consent form. Fifteen stakeholders chose to participate in the project as follows:

1. Medical consultants (n=2);
2. Nursing staff (n=3);
3. Allied health professionals (n=9)
4. Manager situated outside the frontline team (n=1)

### **Data gathering**

Data was collected and analyzed from multiple sources using different methods for a variety of different purposes. The chronology of data collection and analysis is outlined in Table 3.1 below. As highlighted by Greenhalgh et al (2009), realist evaluation uses a pragmatic and reflexive approach to data collection, as appropriate to the unfolding nature of the research over time. I provided formative feedback to participants to inform continuing development work with this team at the end of phases one and two, formative evaluation as a report about more general conclusions about development interventions with teams in difficulty for organization stakeholders at the end of phase three, and a more abstract analysis of complex data for recommendations to organization development practitioners as part of this write up in preparation for wider publication.

I selected methods of data collection in order to create psychological safety for participants and sought to create a participative and constructive experience of the evaluation process. I was influenced by the work of Arranda and Street (2001) in seeking to create space for understanding and sharing multiple viewpoints. The methods of data collection were:

- twelve individual semi-structured interviews using a phenomenological interviewing approach which were audiotaped, with four transcribed in full;
- three pilot individual appreciative inquiry interviews carried out which I audiotaped and transcribed in full;
- five individual appreciative inquiry interviews carried out by a participant using an interview protocol to record the data in written form;

- a discovery and action dialogue with a group of thirteen participants captured through participant notes, drawings and my ethnographic observations. In one hour, participants reflected on eight individual stories created from the appreciative inquiry interview data, and held conversations in pairs and small groups about their own views, finishing with a dialogue as a whole group;
- ethnographic observation in formal and informal settings with participants, including during two team workshops, captured in field notes;
- informal discussions about the project with participants throughout its course, and formal discussions, including during the second team workshop, and email exchanges at the beginning of phases one, two and three;
- research diary recording my own responses to the research process.

The data collection and analysis methods were not all selected at the beginning of the project. The methods in phases two and three were selected in response to emerging findings, my reading, reflections and discussions with peers and advisers.

I selected appreciative inquiry because I was concerned to create psychological safety for participants and an active and constructive framework for the evaluation to promote learning and improvement rather than judgement. The appreciative inquiry movement has been criticized for a lack of published research (Bushe and Kassam, 2005) and peddling magical thinking about team development (Reeves et al, 2010). However, in their overview of published studies of appreciative inquiry, Bushe and Kassam (2005) challenge the traditional organization development action research paradigm focus on what people do rather than how people think. Traditional organization development starts with an ideal model of the team that it assesses the team against, as I did by using the Aston Team Performance Inventory in the prior organization development intervention. I agree with Grant and Humphries (2006) that appreciative inquiry can be used as a method of critical research. By using appreciative inquiry for evaluation there is an intention to learn throughout the evaluation, to encourage dialogue and reflection, and to question assumptions, values and beliefs that form cultural norms (Coghlan et al, 2003). As such it builds the evaluative capacity of the team and works through the simultaneity principle that to inquire is to change (Cooperrider and Whitney, 2005). It is less threatening than traditional evaluation approaches that involve admitting failures and unresolved problems, which can trigger defensive psychological mechanisms.



Appreciative inquiry typically follows a four step process (Coghlan et al 2003), known as the 4-D model, based on the following headings and questions:

1. Discovery: *“what is the best of what is?”*
2. Dream: *“what might be?”*
3. Design: *“what should be the ideal?”*
4. Destiny: *“how to empower, learn and adjust/improvise?”*

(Coghlan et al, 2003, p11, adapted from Watkins and Mohr, 2001)

Phases 2 and 3 of the project were focused on the first three steps of the appreciative inquiry process with a view to creating an evaluation of the team that was generated collaboratively from participants' own experiences and transformed their understanding of themselves through learning and support for each other. I learned about the discovery and action dialogue method at a workshop during the course of the research and this method shares its philosophical and narrative based approach with appreciative inquiry. Sense making and meaning are reached through dialogue and interaction in both approaches, which was suitable for a collaborative emancipatory approach to evaluation. The different interview methods and the reasons for their selection will be explored further in the following three chapters, which describe the project activity and findings.

I chose to employ unstructured ethnographic observation as a method in order to capture the evaluation process in context, and to provide insight into interactions between the team and me. I am aware that I did not seek consent for every conversation or interaction observed which raises ethical issues about exploiting my easy access to the field. In order to manage my ethical boundaries, I took the position of participant observer and narrated myself into the observations using the first person with a view that my feelings and observations are clearly stated as my interpretive constructions of the research field (Mulhall, 2003). My position in relation to the team at the time of my observations was explicitly as practitioner researcher, and my observations were constructed reflexively and respectfully of the team and its individual members. I did not observe interactions covertly or report interactions that did not involve me directly. Where primary data sources were reported such as email, I sought and obtained explicit permission to do so.

Phase One	
Recruited 15 participants	January 2012

Conducted 12 audio-recorded individual semi-structured interviews	February-March 2012
Transcribed 4 interviews	February 2012
Situation Review	March 2012
Initial open coding from 12 interviews	April 2012
Situational Analysis & axial coding	April 2012
Team Workshop (Service Improvement focus)	May 2012
Themes from Phase One & invitation to Phase Two sent to 15 participants	June 2012
Phase Two	
Team Workshop (Change focus & introduction of Appreciative Inquiry)	July 2012
Appreciative Inquiry Pilot with 3 participants	September 2012
Transcribed pilot Appreciative Inquiry (AI) interviews and wrote a summary of each	October – November 2012
Analyzed and reconstructed the AI interview data into stories	December 2012 – January 2013
Phase Three	
3 pilot AI interviewees agreed to interview remaining 12 participants	January 2013
5 AI interviews carried out by 1 participant	February-March 2013
Analyzed and reconstructed the AI interview data into stories	April 2013
Discovery and Action Dialogue with 13 participants	May 2013

**Table 3.1 Chronology of Data Collection and Analysis**

### **Data Analysis**

My doctoral study heightened my awareness of the problems of researcher bias distorting data collection to fit preconceptions (Locke et al, 2010), and the political difficulties of conducting balanced and ethical practitioner research (Fox et al, 2007). I returned to participants both individually and collectively to garner feedback on my data analysis at various points. I undertook to represent a multiplicity of views, and possible interpretations, including my own. I discussed the analysis and my reflections with my academic advisers on a regular basis.

In phase one, I coded the transcribed data from four semi-structured interviews in order to understand the implicit meanings in the data. I found transcribing the interviews emotionally demanding and, at times, overwhelming. I was shocked by the content of the interviews and felt guilty about the way that participants had experienced working with me and continued to feel so negative about their colleagues and work situation. I believe that I was involved in a parallel psychological process with participants, sharing their feelings of disempowerment and guilt about what had happened. As a result, I chose not to transcribe all the interviews as originally planned because I wanted to move onto a more constructive method of evaluation. This was important learning: if I had carried out a small pilot of three or four interviews, I may have discovered that the interview approach chosen was not supportive to the evaluation. However, my experience of carrying out twelve interviews and hearing participants' disappointment and negativity ensured that I recognized that it was widespread within the team, regardless of profession or status. As a way forward, I chose to listen to the remaining eight interviews with the coding framework I had developed and noted additional themes and nuances for each participant, which I incorporated into the framework and situational analysis.

My approach to coding was informed by the principles of grounded theory as described by Kathy Charmaz (2006), in particular her emphasis on identifying both the basic social processes and the basic social psychological processes in the data and noticing the ways in which these were constructed within participant discourses of control and marginalization. Like Clarke (2009), Charmaz contends that basic grounded theory guidelines can be used with twenty first century methodological assumptions and approaches to create interpretive analyses that acknowledge the constructions of reality inherent in research.

Data analysis began as soon as data was collected. I listened to tape recordings to refine the transcription and immersed myself in the data. The transcripts underwent initial coding, keeping an open mind whilst recognizing that I held prior ideas and skills. I followed Charmaz's (2006) guidelines for initial coding to remain open, stay close to the data, keep codes simple and precise, preserve actions, compare data with data and to move quickly through the data. I employed line-by-line coding to reduce the likelihood of imposing my preconceived notions, or of uncritically accepting the participant's viewpoint, and to use constant comparison to make analytic distinctions. Given the project focus on culture change, *in vivo* codes offered the opportunity for a deeper level analysis of collective assumptions, and frames for

action. Using constant comparison, focused coding involved deciding on the most significant and/or frequent initial codes to create a coding framework with which to sift through large amounts of data. I listened to the remaining eight tape recorded interviews for confirming or disconfirming data (Glaser and Strauss, 1967).

### **Situational Analysis**

Having completed the open coding framework, I used situational analysis (Clarke, 2009) as a method to allow different perspectives on the situation to emerge. Drawing on the work of Foucault, Adele Clarke has devised a method based on grounded theory that seeks to:

*“go beyond “the knowing subject”, as centered knower and decision-maker to also address and analyze salient discourses dwelling within the situation of inquiry”* (Clarke, 2009, p201)

This method brought a critical reflexive rigour to my thinking beyond simply locating myself in the situation:

*“the situation itself becomes the fundamental unit of analysis.”* (Clarke, 2009, p210)

Given the role of context, situational analysis provided a method for bringing into my awareness a wide range of discourses, human and non-human elements that were in the situation thereby supporting my reflexivity. The non-linearity of the mapping exercise helped me to see the situation beyond myself as knowing subject and to play with the possibilities for meaning in the context of this team. I found it useful to return to my messy maps in particular to help me consider the situation afresh when I felt stuck. In doing so, I could see how I tended to privilege particular discourses or elements over others. It was particularly helpful at the beginning of the project and I believe it would be a helpful exercise before starting any evaluation/intervention process. It kept the complex, non-linear and fluid nature of this social situation in view and maintained a range of perspectives in the research process rather than a fixed account. Like Liqurish and Siebold (2011) I found that messy maps were useful after coding interviews in order to capture the situation and to generate questions. I found the absence of emotional data in the ordered situational analysis left it rather abstract and distancing. However it was helpful as a meta-analytical tool to map out

micro, meso and macro contextual factors, as background to considering how to work in the micro-context.

I created a messy situational map using the open codes I had constructed, my ethnographic observations and interpretation of the context, using Clarke's guidelines for elements to incorporate in order to lay out "*the major human, nonhuman, discursive and other elements in the research situation of inquiry*" (Clarke, 2009, p210). From these maps I created an ordered abstract situational map. The process of constructing a situational analysis in this way allowed me to reposition my relationship with the project and to consider how best to proceed. I chose to return to the coding framework and grouped the open codes into axial codes in the light of the situational analysis and shared my findings with participants to seek validation.

At the conclusion of Phase One, I formed a hypothesis using Bion's (1968) theory of group dynamics about micro-contexts and psychological mechanisms that produced outcomes in terms of the team's relationships and modes of communication. Phases Two and Three were designed to test my hypothesis using appreciative methods of evaluation. I drew on appreciative inquiry (Cooperrider and Whitney, 2005) and positive deviance (Toth, Benjamin, Lyons Everett, 2010) approaches to organization development and evaluation as both privilege the expertise of research participants and use active and constructive methods of data collection.

In Phase Two, I applied critical discourse analysis to the transcripts of the pilot appreciative inquiry interviews using Labov's (2010) analysis of the structural organization of oral narrative. I analyzed how participants' social practices mediated the complexities, tensions, and contradictions between processes, events and structures in the team (Fairclough, 2005). In particular I sought to identify the linguistic devices participants used to integrate rather than polarize protagonists and antagonists in the interviews. I restoried the data from each of the three pilot appreciative inquiry interviews using Labov's (2010) framework (see Figure 3.1 below) as a guide in order to capture their integrative evaluative point:

*"to transform the social meaning of events without violating our commitment to a faithful rendering of the past"* (Labov, 2010, p548).

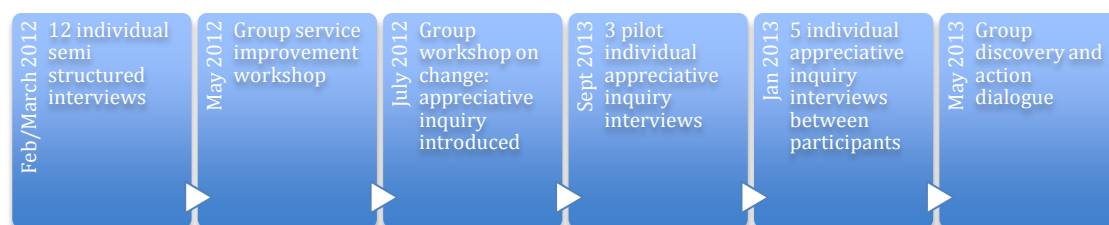
Orientation – introducing the participants in the action, the time, the place and the initial behaviour
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Triggering events – first link in the causal chain, drives narrative towards most reportable event
Evaluation section – series of evaluative clauses, which suspend the action before a critical event and establishes that event as the point of the narrative.
Complicating action – formed of narrative clauses, which respond to the question “what happened then?”
Coda- signals the end of narrative, returns the temporal setting to the present

**Figure 3.1 – Framework for restoried appreciative inquiry data using Labov’s (2010) structure of oral narrative**

In Phase Three, I restoried the written data collected by the five participant-conducted appreciative inquiry interviews. Each re-story from Phases Two and Three was shared with the original teller for validation.

I coded and analyzed the data produced by the discovery and action dialogue using the realist evaluation framework of context, mechanism and outcome in order to refine the hypotheses that I had developed in Phases One and Two. This involved returning to the previous levels of data analysis to confirm or disconfirm findings and to add any new context, mechanism and outcome insights about what worked or did not work for whom and how. An intervention matrix to highlight the chronology of interventions with participants during the course of the research is presented in Figure 3.2 below.



**Figure 3.2 Intervention Matrix**

The movement between individual and group intervention was significant in building psychological safety for the evaluation process, as individual dialogue allowed participants to find their voice in private before entering group discussions, which they highlighted had been particularly threatening both in their workspace and in prior organization development groupwork. The interventions with individuals allowed me to appreciate multiple perspectives in detail before inviting the sharing of individual perspectives in the group interventions. Each intervention was preceded by an emotional shift in my awareness about my own patterns of defensive relating with this team, which allowed me to select methods to encourage more open and trusting relationships between me, participants and the team more generally. As the interventions progressed, participants gained confidence in the evaluation process and I was able to pass ownership for data collection and analysis gradually to them. The emotional working through that was central to this project took place throughout the fifteen months of its course. I believe that it was critical to take time to explore the data gathered, methods of analysis, and implications of each intervention within its context, before starting the next. Emergent evaluation of this type requires commitment of significant research time and personal immersion in the data and field in order to delve beneath the surface.

## **Conclusions**

Learning about the philosophy and methods of practitioner research during my doctoral journey has been intellectually and emotionally challenging. My commitment to a critical realist position has thrown up repeated ethical dilemmas in relation to the project, and the concepts of reflexivity, reciprocity and relationality have been important guides to making methodological choices. In particular, I feel a commitment to the team involved in the research, particularly given my privileged and power-laden position both as organization development practitioner and as researcher. Each step of the process involved consideration of ways to appreciate participants as people, create equality and to allow multiple voices to be heard in the evaluation process whilst recognizing that this final account is an interpretivist construction of my making. I have approached the evaluation as a formative and illuminative exercise rather than a summative exercise of judgement (Greenhalgh et al, 2009). The three phases of project activity and unfolding findings that emerged are described and explored in the following three chapters.





## **Chapter Four: Rolling hitch – attaches a rope to another when the line of pull is almost parallel - methods in action**

*“Inquiry is initiated when, relative to our beliefs, some positive impingement or surprise generates doubt. Then, doubt—experienced as not knowing—motivates a search for understanding. Living doubt is necessary to energize inquiry.” (Locke et al, 2008, p907)*

### **Phase One: Gaining awareness of the context, mechanisms and outcomes of the organization development intervention from multiple viewpoints**

This chapter describes the project activity during Phase One and unfolding findings about context, mechanisms and outcomes. The chapter is structured in chronological order of the activities undertaken and the related findings about the organization development intervention, power dynamics of a clinical team in difficulty and carrying out a realist evaluation of both.

#### **Individual Semi-Structured Interviews**

The first phase of the project began with twelve individual semi-structured interviews to gather participant views about what changes had worked for them (or not) and under what circumstances during the eighteen months the team had been placed in special measures. I arranged the interviews at the convenience of participants in a quiet and comfortable room in the Trust's Academic Centre, away from the team's clinical setting. Interviews were digitally audiotaped. The profession and gender of participants are outlined in table 4.1 below.

**Table 4.1: Interview participants, number, pseudonym, profession and gender**

<b>Participant Number</b>	<b>Participant Pseudonym</b>	<b>Profession</b>	<b>Gender</b>
1	Louise	Allied Health Professional	Female
2	Deborah	Allied Health Professional	Female
3	Clare	Allied Health Professional	Female
4	Kate	Nurse	Female
5	Jennifer	Allied Health Professional	Female
6	Caroline	External Manager	Female
7	Kathryn	Nurse	Female
8	John	Allied Health Professional/ Clinical Team Leader	Male
9	Belinda	Allied Health Professional	Female
10	Paul	Allied Health Professional	Male
11	Michelle	Nurse	Female
12	Trevor	Medical Consultant	Male

### **Interview structure and process**

Recognizing that an interview is a construction or reconstruction of reality (Charmaz, 2006) I devised an interview guide (attached at appendix 3) with the aim of going beneath the surface of ordinary conversation. I was concerned to ensure that the experience of evaluation would not be devaluing, particularly given the prior difficult experiences of the team. I used broad, open questions to invite participants to tell their stories, choosing what to tell and not to tell, and to reflect on earlier events whilst seeking to provide a coherent frame. I devised the questions to provide an opportunity for both summative and formative evaluation of the organization development intervention with an emphasis on positive changes and aspects of work that were enjoyed by participants. I wanted to provide the opportunity for them to share significant experiences with me, to express thoughts and feelings that might be disallowed in other relationships and settings, and for them to receive affirmation and understanding.

Mindful that the dynamics of power, professional status, gender, race and age may affect the direction and content of interviews, I recognised the need to articulate and differentiate my role in the interview from the previous development process being

evaluated. I positioned myself explicitly as a practitioner researcher who had played a significant role in the organization development intervention, and emphasized my respect for their expertise and role both in the clinical team and the change process. The interviews were characterised by my stopping to explore a statement or topic in more depth, or to request more detail or explanation, for example:

*“Kate: I think that could be resolved quite easily if it was picked up and sorted out.*

*Interviewer: Who do you think should be picking it up and sorting it out?”*

I paid attention both to the question and the developing dialogue between myself and the participant in order to penetrate beneath the surface of what was said, for example paying attention to non-verbal cues and to validate the participant's humanity or perspective.

*“Interviewer: your face probably tells me a lot about this anyway but how do you feel about the department at the moment?*

*Deborah: I despair.*

*Interviewer: You despair?*

*Deborah: Yeah I just think it's.-*

*Interviewer: That's a strong word.*

*Deborah: Yeah.*

*Interviewer: You think it's...?*

*Deborah: It's just still a mess.”*

### **Initial analysis of interview data: finding power dynamic of change process**

I transcribed four interviews in full (Participants 1-4) and sent them to my academic advisers. I chose to transcribe three interviews with Allied Health Professionals as they formed the largest professional group in the team (n=12) and one interview with a nurse to provide a different professional viewpoint. I chose to privilege the views of participants who were lower in the professional hierarchy and female, as these voices were often overlooked in my prior experience of the team in the organization development intervention. I left the interviews with the team leader, external manager and medical consultant to the latter stages of analysis as I wanted to focus on understanding the views of those with little positional power.

Through discussions with my academic advisers about the interview transcripts and reflecting on my experiences in my research diary, I identified a power mechanism that was operating in the micro-context when participants interacted with me as an external change agent. Although I had sought to change my role to that of practitioner researcher in the interviews, unconsciously I reverted to my prior organization development role as an expert external change agent. I led the interview dialogues by interrupting and interpreting participants' meaning rather than allowing them to speak freely and lead the dialogue. I had assumed that the organization development intervention was emancipatory, whereas participants voiced experiences of oppression, for example:

*"Louise: no-one told us anything so we only heard bad things which is what always happened and then people like to stir...just Chinese whispers...gets even worse"*

*"Deborah: it felt a bit like a witch hunt"*

*"Louise: I don't think the external things helped"*

*"Clare: I didn't really find it helpful to be honest"*

Responses to my inquiry about their individual influence on the team's development produced replies such as:

*"Clare: I don't think I have any influence at all"*

*"Deborah: I don't have much really."*

*"Kate: I feel like I'm hitting my head on a brick wall"*

As I listened to the interview recordings I recognized that they both highlighted and reinforced my power as an external change agent, and denied participants' agency in the situation:

*"It's strange to hear people talk about me in the third person and to hear what I represent. Power. Control. Judgement."* (Research diary entry)

This led to a finding that, in the micro-context of the organization development intervention, participants experienced a psychological mechanism of oppression, which had led to a relationship outcome of disempowerment and negative feelings (see Figure 4.2 below).

*“Interviewer: Tell me some more about your feelings about that process then. Difficult?  
Deborah: Yeah, it was quite a negative time”*

*“Louise: morale was really low because we didn’t know what was happening. We all just felt quite bad really.”*

<b>Micro-context</b>	Organization development intervention
<b>Psychological Mechanism</b>	Oppression
<b>Relationship Outcome</b>	Disempowerment & negative feelings

**Figure 4.2: Unfolding finding about power dynamic of prior OD intervention**

I used my research diary and wrote a situation review (Costley et al, 2010) to continue the process of researcher reflexivity that discussions with my academic advisers had started. Through doing so, I recognized that the team had become vulnerable as a result of being put into special measures, and that the resultant lack of psychological safety led to the organization development intervention being experienced as oppressive, as illustrated by the following extract:

*“When I wrote my research proposal in the summer, I had not realised the depth of trauma that existed in the department or the threatening nature of action that had been taken “on” the department since I had been involved. I was dimly aware and felt very uneasy at certain points but wasn’t present enough to make sense of it.*

*My recent increased and intense contact with the team again has given me a different perspective and appreciation of the hurt and despair that exists (not just from recent events but as a cultural norm). I think that the project needs to be undertaken in a measured and caring way.” (Situation Review)*

In this context I understood clearly that my evaluation project was not a value neutral act (Vandenberg and Hall, 2011) and that my methodological choices had moral and ethical implications (Iphofen, 2011). Evaluation was not something to do “to” people but “with” them. As I was struggling with this notion, I read a useful article by Richard Seel, an appreciative inquiry practitioner:

*“Organizations change in the direction they inquire”. (Seel, 2008, p6)*

I experienced an epiphany that the process and outcomes of my research could not be separated, and that the direction I chose as a practitioner-researcher would shape the experience for participants and the findings of the research. In this, I was influenced by the post-structuralist position of Adele Clarke:

*“Everything actually in the situation or understood to be so “conditions the possibility” (yes, Foucault) of interpretation and action” (Clarke, 2009, p210)*

### **Constructing codes and situational analysis: finding power dynamics of a clinical team in difficulty**

With this perspective, I coded the four transcripts and listened to the other eight interviews to develop open codes (see Coding Framework, Appendix 4). I constructed a Messy Abstract Situational Map (Clarke, 2009) (see Appendix 5) using the open codes, my ethnographic observations and research diary to surface contexts, mechanisms and outcomes that might be operating in the situation. I began to recognize aspects of participants' professional experience that they valued, which I initially overlooked in the reporting of problems, negative emotion and hopelessness. I hypothesized that the exchange of negative emotion was keeping participants and me *“stuck in a rut”* (in vivo code) and maintaining a culture of deficit and difficulty which prevented them owning and building on their clinical expertise as a team. This exchange of negative emotion was reported as occurring between team members:

*“Louise: some days are worse than others and if one person starts moaning it's like dominoes”*

*“Clare: I just would like no back-stabbing and talking behind your back, and just for everyone to get on”*

*“Kate: there's a lot of tension and bad feeling.”*

I recognized that I repeated and reinforced the negativity in my responses in the interviews, for example:

*“Deborah: There are still problems even though we have our briefing and things, some people really struggle with communication.”*

*Interviewer: Communicating in the sense of don't communicate?*

*Deborah: Yeah*

*Interviewer: Right...right. It must be really difficult.*

*Deborah: Yeah."*

Through his research into group relations, Wilfred Bion (1968) theorized that groups can defend against anxiety by closing in on themselves and denying the possibility of independent thought and co-operative action; he named this defensive process as basic assumption mode. This prevents the group addressing its primary task, or real work, described by Bion as work group mode. The coding and messy situational map suggested to me that participants operated in work group mode when involved in clinical communication during direct contact with patients, and in basic assumption mode when communicating in other work settings, including with me.

Bion identified different basic assumption modes. He theorized that groups sharing a basic assumption dependency behave as if:

*"the group is met in order to be sustained by a leader on whom it depends for nourishment, material and spiritual, and protection" (Bion, 1968, p147)*

Consequently the members of such a group deny their own ability to contribute and to develop themselves and their work by projecting their power onto the leader. In this basic assumption mode, Bion suggested that groups inevitably experience that their leader has failed to be omnipotent. As a result, group members become hostile, either replacing the leader or splitting into conflicting sub-groups to support or undermine the leader. I identified these processes in the data generated by the semi-structured interviews, for example:

*"Clare: he needs to be a bit more of a leader really"*

*"Deborah: We need mother! We need a headmaster! Yeah we definitely miss a manager"*

*"Kate: people have no respect for the management, for the leadership at all"*

*"Louise: there's always people that don't see eye to eye all the time, but those people are always very like strong people, mainly opinionated people."*

I constructed an ordered abstract situational map (Clarke, 2009) that highlighted the multiple discourses in the situation, as well as the major areas of debate and contention (see Appendix 6). Using the map I identified a range of communicative

structures that contributed to social truth claims (Vandenberg and Hall, 2011). I developed a hypothesis that the team operated in basic assumption dependency in its social world constructions and in work group mode in its clinical world constructions. Participants expressed joy and pride in their patient focused work and reported that their team relationships functioned at their best in this context, for example:

*“Kate: There is tension, but I don’t think when there’s patients there, there’s any tension”*

*“Clare: we really enjoy our job and we like working with patients”*

*“Deborah: The patient care. People do look after...it’s with each other the issues. The patients get a really good service, get a really good service absolutely”*

*“Louise: We’re very patient-centred and everything we do is like a common goal...I think we do work well as a team.”*

Translating this into a realist evaluation framework of context-mechanism-outcome, in the micro context of the social world constructions within the team, I considered that the group psychological mechanism was basic assumption dependency, with the outcome of negativity and hostile relationships. In the micro-context of the clinical world constructions within the team when a patient was present, the group psychological mechanism was work group mode, with the outcome of supportive teamwork, enjoyment and delivery of excellent patient care.

<b>Micro-context</b>	Social World Constructions	Clinical World Constructions
<b>Psychological Mechanism</b>	Basic assumption dependency	Work group mode
<b>Relationship Outcome</b>	Hostile team relationships & negativity. Projection of power to act onto leader.	Supportive teamwork & enjoyment. Empowered to act as an individual.

**Figure 4.3: Unfolding finding about power dynamics of a clinical team in difficulty**



### **Methodological change: finding about realist evaluation with a clinical team in difficulty**

The first phase of the evaluation had privileged direct data gathering from participants about what was normative-evaluative for them (Vandenberg and Hall, 2011) and this had the effect of reinforcing the existing dominant power relations between participants and myself, as external change agent, and the psychological mechanism of basic assumption dependency. Having identified that this dynamic may be resulting in disempowerment, and influenced by Tony Ghaye's (2010) methods of enhancing positive relationships, I chose to focus the continuing evaluation on active and constructive methods of data collection and analysis. I aimed to test my hypothesis that there was a highly functioning core to the team (work group mode) that would benefit from being collectively evaluated in more depth. I identified the following positive elements in the abstract messy situational map to guide me in designing the continuing evaluation:

- Enjoying the work
- Excellent clinical skills
- Support for each other
- Small changes happen

I returned to the coding framework and reframed the negativity that was expressed in some open codes into implicit active and constructive codes. I constructed axial codes that linked groups of open codes (positive and negative) with similar underlying constructive meanings (see Appendix 4). I believed that valuing and amplifying aspects of participants' experience that they identified as valuable would create a space for evaluating the team more constructively, and liberate possibilities for change.

I emailed the axial codes to all participants in the research project, requesting feedback or suggestions for changes, with the invitation to participate in the next phase of evaluation, which would focus on positive aspects of the team's work. The axial codes were as follows:

- Helping each other and being supportive
  - Being fair and consistent
  - Being understood by people outside the department

- Enjoying clinical work
- Feeling proud of the quality of patient care
- Protecting the department and the people who work in it
- Wanting agreement about authority and standards
- Bringing in ideas from the outside
- Picking up problems and sorting them out
- Feeling overshadowed by outside events
- Feeling frustrated by negativity

By choosing this approach, I believe that I challenged the basic assumption dependency and experienced a passive response (Ghaye, 2010) from the majority of participants. Thirteen participants did not respond to my email (sent to fifteen participants in total). Of the remaining two participants, Kate replied that she felt I had missed two themes from her interview: lack of communication and lack of leadership. Caroline, the Deputy Senior Manager external to the team, wrote the following email to me:

*“The first 6 points sound like they are aspirations for the team, whilst the next 5 are actions needed. They make sense to me.*

*The inertia to be overcome is huge, despite those aspirations I regularly hear ‘what is wrong with that’ ‘we have always done it like this’ ‘no-one has said it wasn’t good enough before’ ‘we tried x years ago and it didn’t work’ generally endless problems and few solutions and people getting a bit ‘narked’ when someone outside the team (e.g. myself, [senior nurse]) imposes a solution in frustration!”* (Email correspondence)

On my next visit to the department I inquired informally into thoughts about the research project and two participants responded as follows:

*“Morale is so low in here...it’s worse than ever”*

*“People say that you don’t want to do anything about the problems in here....you’re only in it for yourself”* (Field notes)

I said to one participant that I was planning to focus the next phase of the research on working with the positive elements of the department's culture and he responded over his shoulder whilst walking away from me:

*“Start with the management!”*

(Field notes)

These responses seemed to validate my finding about the basic assumption dependency that pervaded the team dynamic, and also challenged me further to understand what I needed to do as a practitioner-researcher to create a constructive and genuinely collaborative evaluation with the team. Reframing the content of the evaluation into active and constructive terms was insufficient, the process of the evaluation also needed to change. Whilst I maintained the lead in the research process, I was “doing to” participants and thereby reinforcing basic assumption dependency. I recognized that I needed to change my position further to enable the evaluation to be “done with” participants.

Micro-context	Phase one of realist evaluation “done to” participants by practitioner-researcher
Psychological mechanism	Basic assumption dependency
Relationship Outcomes	Passivity, hostility and projection of power onto practitioner-researcher by participants

**Figure 4.4 Unfolding finding about realist evaluation process with a clinical team in difficulty**

### **Emerging micro-context changes and formative evaluation at end of Phase One**

The arrival of a new senior operational manager overseeing the department during Phase One of the project provided an opportunity to change the relationship dynamic with participants. She requested my support in facilitating a workshop with the team as she was shocked by their negativity. In a preparatory meeting with the manager and her deputy who was a research participant, Caroline, I described my unfolding findings about negativity reinforcing passivity, hostility towards the team leader and colleagues and the ways that the organization development intervention had reinforced the team's patterns of dependency by imposing special measures and team building on the team.

We discussed maintaining a balance of positive and negative aspects of work, to encourage the team to integrate both, rather than focusing entirely on problems. Informed by my situational analysis, I suggested that service improvement was an area that was often overlooked and might provide a source of constructive energy as participants were proud of their clinical skills and motivated to provide excellent patient care. Therefore, I offered to provide an input on service improvement methods. The senior operational manager responded that she had previously made a presentation to a group of staff about everybody having a management role in a clinical setting and we agreed that this would be a helpful opening to the workshop.

On the day of the workshop, the senior operational manager began by sharing photos of her family, spoke a little about herself personally, and voiced her pleasure in taking responsibility for the team as her professional background was the same as the Allied Health Professional staff. She spoke about her belief that every person has to manage something in their job; so the management of a unit was shared and every person had a part to play. I was impressed by her ability to emotionally engage the team and to hand over authority to this collective of responsible followers:

*“Leadership...the art of engaging a community in facing up to complex collective problems.”* (Grint and Holt, 2011, p11)

The atmosphere in the room gradually changed, as she positioned herself empathically and openly with the team inviting questions and reflections on her presentation. I sought to do the same in my presentation on service improvement methods. The group moved into a reflective process following the two presentations and began to work together identifying service improvements that they could make. Small groups worked calmly and constructively together. It was my first experience of the clinical team in work group mode outside a clinical setting. This led to an unfolding finding that the senior operational manager had effected a change in the leadership-followership relationship through her personal openness, role modeling, empathy and professional identification with the team (see figure 4.5 below).

Micro-context	Team workshop with new Senior Manager presentation that distributed leadership & focus on patient-focused service improvement activities
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Psychological mechanism	Group identification with leader
Relationship outcome	Leadership-followership co-operation and work group mode

**Figure 4.5: Unfolding finding about leadership-followership dimension with a clinical team in difficulty**

Van Dick et al (2007) have researched relationships between leaders' and followers' self-concepts and the implications of followers' attitudes and behaviours. They cite a range of social identity research that suggests:

*“leadership influence stems from the success of leaders in connecting followers' self-concepts to the aims of the group such that follower behaviours that contribute to group outcomes are perceived as self-expressive.”* (Van Dick et al, 2007, p137)

They propose that leaders acting in a group-orientated manner increased the group members' identification and cooperation. Having witnessed this change in the team's behaviour, the second phase of the research was designed to continue to extend the team's functioning in work group mode.

### **Summary**

Setting out on my research journey I experienced a sense of disorientation and loss of direction as I recognized how the semi-structured interviews replayed the dynamic that participants described as disempowering in the organization development intervention. This produced an important finding about the power dynamic of the change process. Using the methods of situational analysis helped me to re-orientate myself by providing a view of the situation beyond myself as knowing subject. This allowed me to attend to aspects of the data that I had previously overlooked and to think creatively about the next steps of the evaluation. I chose to continue the evaluation using only active and constructive methods of direct data collection and to value the aspects of the team that they identified as valuable. Observing the team in work group mode suggested that I had chosen a better track to follow. The next chapter describes the second phase of the project in which participants collaborated in an appreciative inquiry experiment.

**Chapter Five: Alpine butterfly knot – provides a secure loop in the middle of a piece of rope when hikers wish to hook onto a length of shared rope - collaborative inquiry**

*“In Appreciative Inquiry, intervention gives way to inquiry, imagination and innovation.” (Cooperrider and Whitney, 2005, p8)*

**Phase Two: Piloting an appreciative inquiry approach to evaluation**

This chapter describes the project activity and findings that occurred during the second phase of the evaluation. The formative evaluation at the end of phase one led me to generate the process and methods of phase two. The project activities and unfolding findings about the changing power dynamics with the team and the process of the evaluation is described in chronological order.

***Creating psychological safety in the evaluation project: finding trust and reciprocity through appreciative methods***

Drawing on the emancipatory action research of Brown and McCormack (2011), I believed it was important to create a climate of psychological safety in order to enable trust and reciprocity in the evaluation project:

*“The essence of psychological safety is to create an environment where people feel able to focus on underlying issues without threat of loss of self-identity or integrity.” (Brown and McCormack, 2011, p12)*

Bion (1968) theorizes that emotional containment allows groups in basic assumption mode to feel safe enough to integrate positive and negative aspects of their situation. Halton (1994) describes the function of containment:

*“if we can tolerate the feelings for long enough to reflect on them and contain the anxieties they stir up, it may be possible to bring about change. At times when we cannot do this, another person may temporarily contain our feelings for us...What was previously unbearable – and therefore projected – needs to be made bearable. It is painful for the individual or group or institution to have to take back less acceptable aspects of the self which had previously been experienced as belonging to others.” (Halton, 1994, p17)*

At this point in the project, I reflected that containment had helped me in Phase One of the evaluation and the new senior manager's leadership position in relation to the team also seemed to be containing for them. I had a hunch that containment would facilitate the team's movement from a state of basic assumption dependency to work group mode beyond the clinical setting. Containment seemed to be provided by the micro-context of the team's clinical world constructions when a patient was present. However, participants seemed to feel uncontained in the micro-context of social world constructions of the team.

In Phase One of the evaluation, I had recognized my feelings of shame, anxiety and feeling a failure in relation to this team through writing my research diary and situation review. I suggest that these feelings were projective identification with the guilt, anxiety and negativity that participants spoke about in their interviews, and in comments to me in the field. Patterns of blame, victim thinking and defensive relating pervaded the situation and had prevented reflexivity by me or other participants. I felt that we were colluding in basic assumption dependency, caught in defensive anxiety about problems that felt too overwhelming to fix. At this point, I was influenced by the philosophical position of appreciative inquiry as described by Frank Barrett and David Cooperrider (1990):

*"Our efforts to transform defensive routines, when attempted at all, have conventionally been problem focused. However, direct efforts to solve such problems often heighten the very problems they attempt to solve: when attempts are made to make people conscious of their negative attributions towards others and of their defensive attributions in relationships, they all too frequently respond by becoming more defensive." (Barrett and Cooperrider, 1990, p219 )*

My research diary, discussions with my academic advisers, colleagues, thematic analysis of the interviews, situational analysis and reading created a reflexive process through which I was able to acknowledge and contain my lack of confidence and psychological safety as a novice practitioner-researcher. This containment allowed me to seek ways of moving beyond my own subjectivity and to test out methods that would allow a more productive situation to emerge. Once I had changed my position in relation to the research using Clarke's (2009) methods of situational analysis, I was able to move out of the projective identification associated with basic assumption mode and to invite reciprocal relationships with participants:

*“Writing email and listening to interviews, I felt helpless. No idea what to do. Taking on all responsibility myself. Let myself not know – this allowed new ideas to come in. What do I want? What could we do? What could they do – individually?”* (Research diary extract)

In the semi-structured interviews, a number of participants identified that speaking in groups during the organization development intervention had felt psychologically unsafe and expressed a preference for individual dialogue. My situational analysis identified that major areas of contention in the situation were a lack of trust and respect for each other. As a result I reconsidered the evaluation design to create an individual appreciative inquiry interview protocol (see Appendix 7) with the aim of creating a psychologically safe experience of evaluation. I drew on Barrett and Cooperrider's (2001) methods using generative metaphor as an approach for a *“team divided by conflict and caught in defensive perception”* (Barrett and Cooperrider, 1990, p219). I had experienced the power of working with metaphor as a psychotherapist, and knew the work of Milton Erikson, cited by Barrett and Cooperrider (1990):

*“Metaphor invites active experimentation in areas of rigidity and helps people overcome self-defeating defenses.”* (Barrett and Cooperrider, 1990, p223)

In the course of a follow up to the service improvement workshop that the deputy senior manager and participant, Caroline, asked me to attend, I requested an opportunity to discuss my research findings so far, and to explore the possibility of conducting an appreciative inquiry with the team. Caroline had been studying change management and gave a presentation about change involving loss, and incorporated the grief model of Elizabeth Kubler-Ross (1969). I noticed that this was containing for the team and allowed members to inquire into their own process of change and loss. I had prepared a slide presentation informed by Ghaye's (2010) methods for individuals and teams to keep negativity in check and enhance positive relationships and feelings. I outlined that this involved:

- Being appreciative of ourselves and others
- Being open-minded
- Demonstrating kindness
- Always trying to be authentic



I shared that I felt that I had often misunderstood them individually and collectively, and had made mistakes in the way I had worked with them and that I was unsure at times what to do. This public ownership of doubt signaled that I was relinquishing my power as external change expert, and generated a genuine invitation to co-participants to help me understand:

*“doubt – experienced as not knowing – motivates a search for understanding. Living doubt is necessary to energize inquiry” (Locke et al, 2008, p908).*

I shared a humorous poem to illustrate how changing focus to something pleasurable could transform feelings about difficult situations:

*“When I am sad and weary  
When I think all hope is gone  
When I walk down High Holborn  
I think of you with nothing on.”*

“Celia Celia” by Adrian Mitchell

By choosing this poem I introduced a generative metaphor into the dialogue, again influenced by Barrett and Cooperrider (1990):

*“The poetic process helps us appreciate the fact that many futures are possible and that human realities are both discovered and created. As Bruner (1986) has elaborated the function of the poetic is to open us up to the hypothetical, to the range of meanings that are possible.” (p230)*

I invited the team to participate in the next phase of the project, which was to pilot and create together an appreciative inquiry process to evaluate the positive core of the team. I accompanied my invitation with a picture of champagne in a bucket, a visual metaphor for congratulating and appreciating the team, and there was laughter and banter from the group. In their case study of working with a team in conflict, Barrett and Cooperrider (1990) reported a relaxation of tensions, and the emergence of playfulness, laughter and lightness as participants began to experiment with appreciative relating.

In this discussion, members of the team began to share their emotional responses to change more openly and to discuss some of the emotional challenges that faced

them, in particular a looming inquest relating to the serious clinical incident that had happened at the beginning of the organization development intervention, and discriminatory treatment that some of the female team members felt they received. One of the participants returned to the room after the workshop had finished to report that a colleague was in tears about the inquest and her feelings of guilt about what had happened.

I visited the team's clinical setting immediately following the workshop and a member of staff whom had refused to speak to me in the past was giving the tearful colleague a hug just before she left to go home. After the colleague had left, she pointed me into the team's seminar room with a pink feather duster. I felt and expressed delight and surprise as I walked into the normally dingy and unloved seminar room. It was decorated in pink and white ready for a tea party that team members were preparing for the retirement of a cherished colleague. Offering me a different view of the team, the staff member said that I could see that they did appreciate each other. I agreed that I could, and left having recognized that they could transform their situation, as they had this room.

From this day, my relationship with the team and research participants changed. Individuals began to seek me out for advice and support and I was invited to the team's Christmas Party. It seemed to me that trust and respect had begun to develop between us, so that the social world constructions in relation to Caroline and me changed, and we entered a relationship of reciprocity and an ability to genuinely collaborate with the team in the evaluation process (Hall and Callery, 2001). In describing her work with organizations, Pooley describes this as:

*“the creation of a working relationship between coach and client that tolerates the capacity to both know and not know; to find answers to questions in surprising spaces, and to work with the idea that there is often new meaning to be found underlying the presenting issues in the client and in their sphere of influence.”* (Pooley, 2004, p187)

In terms of realist evaluation, figure 5.1 illustrates the creation of a micro-context by Caroline and myself using appreciative methods, in particular the ownership of feelings of loss and doubt, poetic process and generative metaphor, providing the psychological mechanism of containment, as defined by Halton (1994), with the

relationship outcome of trust and reciprocity between myself and participants, and across a second social boundary between Caroline and other participants.

Micro-context	Group discussion using appreciative methods: ownership of feelings of loss and doubt, poetic process, generative metaphor.
Psychological mechanism	Containment
Relationship outcome	Trust and reciprocity between practitioner-researcher and participants & between participants across social boundaries

**Figure 5.1: Unfolding finding about creating trust and reciprocity through appreciative methods**

***Appreciative inquiry interview pilot: finding split off positive aspects of self, other and team***

Three participants offered to pilot the appreciative inquiry interview protocol with me. The participants were John, the team leader who was a male Allied Health Professional, Paul, a second male Allied Health Professional, and Kathryn, a female nurse. The interviews took place in a quiet, comfortable room in the Academic Centre, were audiotaped and transcribed in full. One interview lasted 6 minutes, one lasted 16 minutes and one lasted 22 minutes, which contrasted to the lengthy semi-structured interviews in Phase One. Learning from those interviews, I ensured that I allowed space for participants to consider their answers, validated their humanity and stayed within the interview protocol questions, for example:

*“Interviewer: So what you valued about yourself was? #00:05:50-6#*

*John: The thing I valued about myself was my ability and willingness to, to act as part, being non-disruptive, I valued about myself my ability to be, to work with others and to (6 seconds) I've not had a stroke I'm thinking. #00:06:30-1#*

*Interviewer: I can see, yeah, you're thinking well. #00:06:30-4# “*

The three participants reported favourably on the interview design: it helped them to focus on what worked well and, whilst this was challenging, it was valuable for them. They agreed that it was helpful to include an external team experience as well as the current team experience to help them generate understanding of what worked well

for them. I asked if they felt we should change any element of the design, and that perhaps three wishes were too many. They were emphatic that the pilot should be used with all participants.

Each pilot interview produced an account of positive aspects of teamwork in relation to caring for patients. I found that the constructive focus of appreciative inquiry prevented the recounting of negative experiences that would reinforce individual or team deficits. There were times when negativity emerged and the interview framework supported me to keep the dialogue integrative rather than polarizing, for example:

*“Interviewer: What else? Think about what made those moments really positive. How would you like people to be? #00:12:06-6#*

*Kathryn: Just to help each other, to back each other, when you're working in the room, think what that person wants do you know what I mean, be there so it all runs smoothly. And like even at the end of a case be there to help, like on Friday they all disappeared, AHPs, I was on my own with the anaesthetic nurse and the patient. #00:12:35-2#*

*Interviewer: So staying to help. #00:12:35-2#*

*Kathryn: Yeah, and then John will pass me another job and I'm stuck with another patient, a poorly patient, and I said to John, can someone come in stand with the patient while I deal with this one, "I'm busy", and you think "John I can't be in two places at once!" There's a patient there that needs sorting for Monday I was given the notes and like book a bed, but I still had his patient from the embolisation. So they need to really think, yes you've got this to do but I have also got something else to do and yes I'll help you but they just don't seem to like think. #00:13:17-5#*

*Interviewer: Is it something about putting themselves in your shoes? #00:13:21-4#*

*Kathryn: That would be nice (laughs). Just for a moment to think. #00:13:24-8#”*

This suggests that individual appreciative inquiry interviews provided an opportunity for participants to focus on underlying constructive processes:

*“in the work group a conscious effort has to be made by each individual to understand the other person as they work together....members co-operate to*

*achieve a common task and, because they are in touch with reality, develop and change as they succeed.” (De Board, 1978, p42)*

This led me to hypothesize that the appreciative inquiry interview had helped these participants surface positive aspects of themselves and other members of the team in work group mode that occurred in the micro-context of clinical settings, and consider how to integrate these into the other settings that they inhabited together (see figure 5.2 below). However, the concluding question about three positive changes that would ensure that the current team was always like this tended to elicit polarizing rather than integrative responses, for example:

*“Paul: Tell people to stop being so negative. #00:05:33-7#*

*Highlight individuals who are negative and ask them to change. #00:05:37-2#*

*And praise the ones who are being positive and wanting to change. #00:05:46-8# “*

Micro-context	Appreciative inquiry interview
Psychological mechanism	Integration of split off positive aspects of self, other and team
Relationship outcome	Positive and productive teamwork acknowledged as important to self and others

**Figure 5.2 Unfolding finding about integrative mechanism of Appreciative Inquiry**

***Discourse analysis and restoried data: finding mechanisms for team integration through oral narrative***

I chose to restory the appreciative inquiry data to highlight the positivity contained in the interviews and to use the stories as a basis for a team discovery and action dialogue, but my first drafts were lifeless and lacked integrity. I read an article by sociolinguist, William Labov on the structural organization of oral narrative. By applying Labov’s (2010) structure of oral narrative, I used discourse analysis to analyze the transcribed appreciative inquiry interview data, in particular their evaluative aspects:

*“Most adult narratives are more than a simple reporting of events. A variety of evaluative devices are used to establish the evaluative point of the story”*  
(Labov 2010, p547)

I identified how participants assigned praise or blame to critical events or relationships in the appreciative inquiry interview and how they conveyed the social meaning of their experiences. Examples of integrative evaluative clauses identified in the transcript of Paul’s interview:

*“Bringing in the business from the pain team, I think has been one of the best things I’ve done”*

*“who I rate highly and he doesn’t suffer fools at all”*

*“they’re really nice people and they made staff feel really nice”*

*“so it’s making people feel better as a team”*

*“so I had the positives of we can do that”*

*“it’s a nicer room and the staff wanted that in there. So everybody likes working in there”*

*“they really wanted to do it. They looked forward to it”*

*“And then that snowballed”*

*“We all worked together as a team. We got some people AHPs doing a bit of nursing job. It works really well.”*

*“It’s down to the staff.”*

*“we can do things that we’ve not done before with very little difficulty”*

Having identified the key integrative components of the transcripts, I created a framework based on Labov’s (2010) structure to reconstruct the data into individual stories, to reduce observer effect, and to convey the positive evaluative and integrative elements of the participant narratives (three stories attached at appendix 8). I emphasized the constructive element of each story by summarizing “what worked well for me” in a separate section at the end.

***Appreciative inquiry carried out between participants: finding participants empowered to collaborate in evaluation using their own frame of reference***

I shared the story derived from their interview with each individual participant and received positive feedback. I asked the three participants if they would be willing to interview their colleagues who were participating in the research using the same interview framework, capturing the information in written form. I offered to restore

this information in the same way I had with their interviews and proposed that these could form the basis of a discovery and action dialogue workshop with participants. They agreed that they would like to do so, and I supplied them with a pack of five interview protocols each. I invited them to carry out the interviews in the coming month.

I hypothesized that passing the appreciative inquiry to participants to carry out between them would support them in evaluating their own process and create a different power dynamic (see figure 5.3 below). I wanted to find out whether hearing each other's viewpoint about what worked well for them as individuals would lead to reflections about what worked well for them as a team and allow participants to move into mutual containment, co-operation and work group mode, rather than basic assumption mode. In the philosophy of appreciative inquiry (Cooperrider and Whitney, 2005, Seel, 2008) organizations begin to change as soon as questions are asked, therefore inquiry is the change process rather than a separate diagnostic process, which had been my previous understanding from a traditional organization development perspective.

One of the participants, Kathryn, went on unplanned sick leave for a month shortly after she had agreed to conduct the interviews and Paul chose not to conduct his interviews in the month available. The team leader, John, carried out five interviews with four allied health professionals and one nurse, and reported that the conversations were constructive and helpful to him and the other participants. I restored the data and John shared the stories with the participants and gained their permission to share them in a group discussion. He agreed to arrange the discovery and action dialogue based on the eight stories that had been created with him inviting all participants to take part.

Micro-context	Realist evaluation in phase 2 being "done with" and by participants
Psychological mechanism	Work group mode
Relationship Outcomes	Participants empowered to evaluate individual and team strengths

**Figure 5.3: Unfolding finding about realist evaluation with a clinical team in difficulty**

## **Summary**

Phase Two was a significant stage in my practitioner researcher development as I took the risk to own my doubt and to take a different stance with the team. The development of trust and rapport with participants opened up the possibility for us to continue the evaluation using the collaborative method of appreciative inquiry. Having recognized the team's ability to change their own situation, I entered into a more active and constructive relationship with them. As I was freed from my counter-transference response to the team's basic assumption dependency, I became more creative and flexible in the way that I viewed the project and possibilities for developing it. The leadership style of the two managers involved contained the team's anxiety and changed the leadership-followership dynamic of the team to work group mode. The pilot appreciative inquiry interview challenged individual participants to evaluate positive aspects of the team, which changed the normalized pattern of deficit thinking and feeling about the team. Their view was that the interview was a useful exercise. Using discourse analysis helped me to identify and understand the narrative elements that participants used to evaluate their experiences using praise and blame. I re-storied the data in order to highlight the integrative and praising elements of their stories. The three pilot appreciative inquiry participants agreed to interview the remaining participants. Only John, the team leader carried out this exercise. I agreed with him to hold a discovery and action dialogue using the stories collected as a starting point. The final phase of the evaluation which was the discovery and action dialogue and its findings will be covered in the next chapter, along with an overview of the refined realist evaluation findings from all three phases in relation to the original research questions.



**Chapter Six: Bowline knot – used to make a fixed loop in the end of a rope - team evaluation in action**

*“Stories are not a symptom of culture, culture is a symptom of storytelling”.*

(Weick and Browning, 1986, p. 249)

**Phase Three: Discovering the team’s positive core and refining theory about what works for whom, in what circumstances and how**

This chapter describes the project activity and findings that occurred during the third and final phase of the evaluation. It describes the activity and unfolding findings in chronological order in relation to changing the power dynamics through facilitating a group evaluation, and emancipatory developmental contexts, mechanisms and outcomes for a clinical team in difficulty. The chapter continues with a refinement of theory about the contexts, mechanisms and outcomes found in relation to the evaluation project as a whole. It concludes with consideration of the possible limitations of the methods and design strategies used.

***Creating a Discovery and action dialogue: finding about power dynamics of facilitating group evaluation***

The process and outcomes of Phase Two reinforced my trust in and understanding of the positive core at the heart of the team, and that team members had the capacity to discover this core in one to one dialogues structured by the appreciative inquiry interview. The structure seemed to provide the containment necessary to allow the positive elements of individual experience to be made conscious and integrated into the experience of the individual participant’s professional self, and of self in relationship to other. The ability to hold both good and bad parts of the self together is fundamental to healthy individual and team development and central to the ability to tolerate change:

*“This integration of opposite perceptions and emotions represents first steps in psychological integration and formation of a worldview – a realization that the self contains conflicting emotions, that other people are separate from the self and that they have other relationships in a family system.”* (Halton, 2004, p110)

I was considering appreciative inquiry methods for broadening these one-to-one experiences into a group experience to test whether this individual raising of awareness would be possible for participants in a group setting. I recalled the

warning from the one-to-one interviews in Phase One of the fear and dislike of the team building workshops I had held in the prior organization development intervention. I believed that the resources participants had created in the eight stories could provide the foundation for the discovery and dream stages of a team appreciative inquiry cycle as formulated by Cooperrider and Whitney (2005):

- Discovery: Mobilizing the whole system by engaging all stakeholders in the articulation of strengths and best practices.
- Dream: Creating a clear results oriented vision in relation to questions of higher purpose.
- Design: Creating possible designs of the ideal organization.
- Destiny: Strengthening the affirmative capability of the system.

Cooperrider and Whitney (2005) proposed a group dialogue around these themes and I was conscious that I needed to create a format that was distinctive from previous team building exercises, privileged the voices of participants and supported me to hand over power to them as a group. I was concerned that the basic assumption dependency mode could re-emerge and damage the containment and psychological safety that had been created by Phase Two.

Whilst I was considering the design of Phase Three, I was fortunate to attend a leadership workshop held at my Trust by Arvind Singhal, Professor of Communication and Director of the Social Justice Initiative at the University of Texas at El Paso. Dr Singhal was introducing an approach called positive deviance, which he had been researching with healthcare organizations in the United States (Singhal, Buscell and Lindberg, 2010). Like appreciative inquiry, the positive deviance approach to change focuses on what works well and following the wisdom of people on the ground rather than expert-led change interventions. Dr Singhal led an experiential group process in which he introduced a series of “liberating structure” methods to facilitate discussions, which aimed to allow everybody in the group to participate and contribute equally to the conversation. Like appreciative inquiry, discussions began with an invitation to think about an affirmative topic, for example: *“Consider a time when your team functioned at its highest potential”*. He demonstrated the liberating structure called “1-2-4-All” following the facilitation framework outlined in Table 6.1 below.

**Table 6.1 Liberating structure “1-2-4-All” group facilitation framework**

Activity	Time
Silent self-reflection on own	1 minute
Share ideas from self-reflection in pairs	2 minutes
Share ideas from pair in fours, notice similarities and differences, write shared ideas about what works on a flipchart	4 minutes
Move into whole group discussion – each group of four places flipchart on the floor in the middle of a circle and ideas are shared, similarities and differences noticed	8 minutes

In Dr Singhal’s workshop I noticed the group energy generated by this method and decided to test it with a group outside the research context and then, if successful, to incorporate it into the research design. At the end of the workshop I obtained a copy of the book *Inviting Everyone: Healing Healthcare through Positive Deviance* (Singhal, Buscell, and Lindberg, 2010) and read more about the use of discovery and action dialogues in a variety of healthcare settings to involve frontline staff. In particular I was struck by the proposition that discovery and action dialogues were:

*“brief facilitated conversations [that] alleviated the need for big meetings that were hard to schedule in a hectic environment where shift work covers 24 hours...No ideas are ridiculed or dismissed. Ideas are “butterflies” to be examined with care and treated gently.”* (Buscell, 2010, p77)

This method offered a way for me as change agent to “become invisible” (Toth et al, 2010, p168) and to distribute leadership of group discussions, so that participants could discover and put into action their own ideas and decisions. I felt that the opportunity for self-reflection and pairs dialogues would create psychological safety for participants, with a further step of discussions in groups of four, before inviting a whole group conversation. I hoped that this would build towards shared understanding and break the cycle of deficit relating and underlying basic assumption of dependency that had tended to emerge in group dynamics in non-patient settings.

I piloted the method with another group of frontline staff and found that it generated the same energy and freedom of expression I had experienced in Dr Singhal's workshop (see Figure 6.1). Anton Obholzer and Sarah Miller suggest that structure enables the facilitation of creative interaction between leaders and followers:

*"The question about how important structure is in the area of institutional "working through" of issues is often raised. A lack of structure makes for a process that easily succumbs to the basic assumption activity described so lucidly by Bion."* (Obholzer and Miller, 2004, p46)

Micro Context	Pilot discovery and action dialogue using 1-2-4-All method
Psychological mechanism	Containment & psychological safety created by structure
Relationship Outcomes	Diminished power differentials, sharing of multiple viewpoints, natural building of consensus

**Figure 6.1 Unfolding finding about power dynamics of facilitating group evaluation using a discovery and action dialogue**

***Moving from individual to team process: finding work group mode in a social world construction***

Having piloted the discovery and action dialogue methods, I consulted and agreed with the team leader, John, to hold a discovery and action dialogue for this team based on the stories created by the appreciative inquiry. He organized and invited participants to a one-hour meeting in a fortnight's time, at the beginning of a shift in the seminar room based in the team's clinical setting. We agreed that this amount of time and setting would facilitate attendance. I asked him to brief participants about the activity at the next team briefing.

I considered how to blend the discovery and action dialogue with the appreciative inquiry methods already used. I created an A3 poster for each of the eight stories using different fonts to emphasize the unique voice of each one (example of Louise's Story at Appendix 9). By using only their first name, I sought to present individual stories as belonging to equal human beings, free from their hierarchical or professional role. I planned to display the posters around the seminar room and to invite participants to walk round and read them. I prepared four questions:

- What have you discovered through reading the stories around the room?
- What do you appreciate about the positive core of you and your colleagues?
- What would this department look like if it were designed in every way possible to maximise the qualities of this positive core – what would you experience?
- What does this call you to do next?

In order to minimize the possibility of my voice dominating the meeting, I decided to type up the questions and to produce paper slips for each question so that I could hand them out to individual participants. Choosing to break the normal materials associated with hospital meetings, I obtained coloured circles of paper and pencils to hand out for participants to capture their thoughts, and A3 paper and marker pens for the work in groups of four. Prior to the meeting, I checked that the room had chairs set out in a circle without tables, and just before we began I arranged the eight posters around the walls of the room like a picture gallery.

Thirteen participants took part in the discovery and action dialogue (see Table 6.2 below). As participants arrived I invited them to read the stories around the room. Participants chatted with each other as they read the stories. As they completed reading, I handed them individually the first question and a paper circle and pencil to capture their thoughts. I invited them to reflect on their own for one minute. As individuals looked as though they were completing their thoughts, I gave them the second question and another minute to consider and capture their ideas. Then I invited them to find a partner and to share their thinking for two minutes. I gave them the third question to consider and another two minutes. I invited them to partner with another pair into a group of four or five and asked them to share their thoughts, and, as this dialogue naturally died down, I gave each group four minutes to create an A3 poster capturing their ideas about the third question.

After four minutes, the groups were in deep discussion so I gave them a further four minutes to continue and complete their poster. As the posters were completed, I invited the two groups to place their posters on the floor, to form a circle around them and to walk slowly around the two posters to see what they noticed. The participants

held a self-directed conversation for ten minutes, and as this drew to a close I posed the fourth question by holding the slip of paper in front of me, and saying it out loud. The participants made plans about how they'd like to take the work forward. We finished after 55 minutes. I thanked participants and wished them a good rest of the day at work.

**Table 6.2: Discovery and action dialogue participants, number, pseudonym, profession and gender**

<b>Participant Number</b>	<b>Participant Pseudonym</b>	<b>Profession</b>	<b>Gender</b>
1	Louise	Allied Health Professional	Female
2	Deborah	Allied Health Professional	Female
3	Clare	Allied Health Professional	Female
5	Jennifer	Allied Health Professional	Female
7	Kathryn	Nurse	Female
8	John	Allied Health Professional/ Clinical Team Leader	Male
9	Belinda	Allied Health Professional	Female
10	Paul	Allied Health Professional	Male
11	Michelle	Nurse	Female
12	Trevor	Medical Consultant	Male
13	Nigel	Medical Consultant	Male
14	Pat	Allied Health Professional	Male
15	Melanie	Allied Health Professional	Female

***Analysis of discovery and action dialogue data: finding emancipatory context created by appreciative methods***

I analyzed the discovery and action dialogue data using a framework identified by Cooperrider and Whitney (2005) drawing on the research of Diana Whitney and Amanda Trosten-Bloom:

*“Their key finding is that Appreciative Inquiry works by generating six essential conditions in an organization that together liberate or unleash personal and organizational power (potential).” (Cooperrider and Whitney, 2005, p56)*

I analyzed the data for the following six conditions:

- Freedom to be known in relationship
- Freedom to be heard
- Freedom to dream in community
- Freedom to choose to contribute
- Freedom to act with support
- Freedom to be positive

Thirty two written comments from seven participants were collected and are included in full at Appendix 10. Two A3 representations of small group conversations were also collected (see Appendix 11). I wrote detailed field notes immediately after the workshop.

#### *Freedom to be in relationship*

For the first time in my experience of this team, people from all clinical disciplines attended a workshop with me voluntarily, without an external manager requesting people attend. The hierarchy was flattened by the 1-2-4-All method, which generated conversations across hierarchy and discipline. The stories presented individuals as equal human beings, free from their hierarchical or professional role. Participants formed relationships in the room by choosing to whom to speak and how to respond to the questions and the stories. Medical consultants, nurses and allied health professionals worked together. Written data collected from participants in response to the three questions included:

*“The majority of experiences express helping others and being helped themselves as part of a team where everyone knows their roles and limits”*

*“The need to recognise, acknowledge and compliment people in their achievement”*

*“Each team member would feel as if they were making a valued contribution.”*

*“Everyone would feel respected and appreciated”*

### *Freedom to be heard*

The appreciative inquiry interview created an opportunity for individuals to be heard by a colleague in a constructive dialogue. The re-storying of their interview data into a poster presentation at the discovery and action dialogue workshop gave a further opportunity to be heard as an individual human being rather than in role. The 1-2-4-All method allowed each individual to be heard by a number of different colleagues in the course of the workshop. Written data collected from one participant identified the importance of being heard:

*“I would experience being valued, appreciated for hard work. To be listened to if I have any thoughts and ideas as to how the department can move forward and to put these into practice.”*

The workshop methods ensured that my voice was minimized, and this created space for the discovery process to be handed over to front line staff.

### *Freedom to dream in community*

Two small group discussions produced the posters in Appendix 11 in response to the question: what would this department look like if it were designed in every way possible to maximise the qualities of this positive core – what would you experience? Both figures highlight the move from “*linear causality (victim/blame thinking)*” (Pooley, 2004, p175) identified in the semi-structured interviews in Phase One to:

*“circular causality (“what I do affects him and what he does affects me and we are all part of other teams and systems that influence each other and each other’s behaviour”)”* (Pooley, 2004, p175).

This suggests that the methods supported team reflexivity and an awareness of the team in context. Figure 2 in Appendix 11 included patients and another department as actors in the situation. Appreciative inquiry had created a space for the valued relationship with patients to be acknowledged and built upon as a source of positivity, which was echoed in the written data collected at the workshop:

*“All staff share commitment to making the department work and assist the patient to the best of their ability.”*

*“People are happy when they have achieved a good result for patients.”*

*“Everyone is focused and patients come first.”*



*“Patient oriented, everyone thinks it is good when the patient is central to what we do.”*

*“A hard working valued team striving to give the patient the most best possible experience whilst they are here.”*

*“Patient care is the ultimate goal.”*

*“Patients having a good experience.”*

My situational analysis in Phase One had allowed the silences in the situation to speak (Clarke 2005) so that I became aware of the missing relationship with patients and the distinct cultural difference in the way that the team related in clinical settings with patients. Dreaming in community through the discovery and action dialogue gave full voice to this aspect of participants’ experience.

#### *Freedom to choose to contribute*

Two participants joined and two different participants left the workshop according to clinical commitments during its process. This permeable workshop boundary allowed participants to choose if and how much to participate. At the beginning of the workshop, one of the participants who had participated in the appreciative inquiry interviews said that he had not seen his story before the workshop and began to take it off the wall. As he read it, I apologized that he had not seen it before, and that he was welcome to remove his story. He chose to leave it on the wall. The 1-2-4-All format gave individuals the opportunity to contribute in various ways; reading, writing, telling, listening, sharing views with different participants, and drawing.

#### *Freedom to act with support*

The appreciative inquiry stories surfaced a theme of enjoying feeling supported and providing support to others, which was echoed in the workshop data:

*“Support, recognition from colleagues”*

*“A happy team, encouraging, supporting.”*

#### *Freedom to be positive*

The constructive frame of the four workshop questions generated conversations each of which provided an evaluative opportunity to construct a more positive and fulfilling future in participants’ own terms. The stories and written data collected from participants suggested that freedom to be positive was important to them:

*“Happy staff and patients. Supportive enthusiastic staff. Smoother running service.”*

*“Everyone positive and supportive of other people.”*

The ratio of positive to negative communication during the hour and in the written data collected was high. Of the thirty two written statements collected, thirty one were active and constructive and one was framed negatively:

*“Stop putting us in situations that provoke arguments and bad feeling.”*

In the whole group, as the discovery and action dialogue figures in Appendix 11 were shared, I posed the final question: “What does this call you to do now?” One participant asked me in a bewildered voice:

*“Why can’t we do this all the time?”* (Field note)

I said that it was a very interesting question and left the group to answer. This supports Bushe and Coetzer’s (1995) experience that appreciative methods push frustration to the surface to the point where participants voluntarily express what they have been afraid to express in the group. This can be both cathartic and healing.

Following this question, the whole group conversation continued with individuals expressing a commitment to support each other more routinely and involved spontaneous positive feedback from the most senior to the most junior member of the team about how well she had learned new skills and supported him. This was followed by group applause, and a comment from another junior and the newest team member:

*“I have seen fantastic care for patients and for me here...people in this team don’t pat themselves on the back enough”. (Field note)*

The data generated by the discovery and action dialogue supported a finding that using an appreciative framework for evaluation led to team construction of what worked for them in a way that reconnected them with their primary task, in the sense formulated by David Armstrong (2010) of “practice”, “primary spirit” or “animating principle” and generated a recognition of participants’ relatedness and interdependence not only with each other, but with the patient (see figure 6.2).

Micro-context	Discovery and action dialogue constructing collective social and clinical world
Psychological mechanism	Freedom to connect with vital developmental task in work group mode
Relationship outcome	Team integration, co-operation, equality of voice, catharsis, interdependence with colleagues and with patients

**Figure 6.2 Unfolding finding about emancipatory context for development created by Discovery and Action Dialogue**

I found that the appreciative framework linked to Bion's conceptualization of work group mode and created conditions for its emergence:

*"In my experience, the psychological structure of the work group is very powerful, and it is noteworthy that it survives with a vitality that would suggest that fears that the work group will be swamped by the emotional states proper to the basic assumptions are quite out of proportion."* (Bion, 1968, p98)

In his analysis of work group mode, David Armstrong (2010) suggests that *"work group is an expression at the group level of a developmental push"* (Armstrong, 2010, p143) which compels people to learn through experience, and that basic assumption mode is group expression of an unconscious regressive pull away from having to learn from painful experience. He suggests that these are poles in mental functioning that co-exist in the subconscious: work group mode is called forth by engagement with the developmental task in hand, and basic assumption mode by avoidance of it.

In asking myself why it had taken so long for the patient to come clearly into view in the evaluation of this team's change process, I recalled the seminal research of Isabel Menzies (1960) into the tensions and conflict found in the nursing culture of a general hospital whereby *"changes threaten existing social defenses against deep and intense anxieties"* (Menzies, 1960, p451). Again Armstrong's (2010) description of the duality of work group and basic assumption mentality was helpful:

*“What is then missed is something one might call the shadow of development: the communication of an inner struggle that is at once both organizational and personal; the encounter with something not known or known but not formulated, which may certainly repel but may also attract.”*  
(Armstrong, 2010, p148)

I would argue that the shadow of development for this team was both the joy and fear of being involved in patient care, particularly as a serious clinical incident involving a patient had led to the team being placed in special measures. I believe that I was involved in a parallel process with the team, which prevented me and them seeing the importance of patients to their collective sense-making. This suggests that it was vital to create conditions within which engagement with the core developmental task (patient care) could be joyful, and allowed individuals to express positive aspects of their current experience, so as to contain anxiety about loss, whilst considering ways of developing a better future for the team and their patients. Stories about peak experiences in the team mostly involved having a positive experience with a patient. The silence that now spoke to me was that the pain associated with harming a patient had not been fully grieved by the team.

I returned to the axial coding from Phase One to code the discovery and action dialogue (attached at Appendix 12) and found that there were no comments relating to the following codes:

- Being understood by people outside the department
- Wanting agreement about authority and standards
- Picking up problems and sorting them out
- Feeling overshadowed by outside events

There was only one comment that linked to the code:

- Feeling frustrated by negativity

These codes could be seen as symptomatic of basic assumption dependency mode and a state of passive followership. The data coded more strongly to the following codes:

- Helping each other and being supportive
- Being fair and consistent
- Enjoying clinical work
- Feeling proud of the quality of patient care
- Protecting the department and the people who work in it

The codes above could be seen as indicative of work group mode and a state of distributed leadership and teamwork. However, my axial codes did not capture the joy and meaning of this new data nor the central importance of the patient as a person with feelings and an active participant in the daily life of the team, for example:

*“Striving to give the patient the most best possible experience whilst they are here.”*

*“Happy staff and patients.”*

*“Patients having a good experience”*

As John had expressed eloquently in his appreciative inquiry interview:

*“you're there til half past seven at night and at the end of that you've been there for six hours and that patient is then, whilst not potentially cured but they are then, have had the treatment that they need to have and that's very satisfying, because that's the whole point of being here in the first place.”*

I recognized that, until this point, I had not appreciated fully the importance of relationships with patients for this team, and the resources for joy and meaning that this provided them and me in seeking to support their change process. I had not seen patients as real people but as a function of clinical work in the way that I had coded the Phase One data. In view of the discovery and action dialogue data I theorized that relationships with patients and creating a positive experience for them were animating principles for this team on which they could build their own framework for sustainable development of their social as well as clinical world constructions, illustrated by their diagrams in Appendix 11. This led to the findings outlined in figure 6.3 in relation to developmental contexts, mechanisms and outcomes for a clinical team in difficulty.

Micro-context	Special measures intervention in response to errors in patient care	Appreciative inquiry and discovery and action dialogue
Psychological mechanism	Basic assumption regression from pain of learning from experience and from feelings of loss	Work group engagement with pleasurable learning from experience and with feelings of relatedness
Relationship outcome	Splitting from colleagues and patients	Interdependence with colleagues and patients

**Figure 6.3 Unfolding finding about developmental contexts, mechanisms and outcomes for a clinical team in difficulty**

***Refinement of Context, Mechanisms and Outcomes about what works for whom, in what circumstances and how***

Following Phase Three, I returned to the original research questions to summarize and refine the project findings about what worked for whom, in what circumstances and how in relation to this clinical team.

***1. How does a clinical team identified as being in difficulty experience a change process directed at changing team culture?***

Phase One of the evaluation led to a finding that team culture was not a discrete entity but continually constructed and reconstructed by the actors, discourses and elements in the situation. Individual interviews about the experience of the prior organizational development intervention led to a finding that participants had found this oppressive with an outcome of disempowerment and negative feelings about work and colleagues. Analysis of the current social world constructions of participants led to a finding of a state of basic assumption dependency that operated within and between team members leading to hostile team relationships and the projection of power to act onto the leader. This resulted in a vicious circle of negative feelings towards the team leader, external managers and each other. The organization development intervention had reinforced the basic assumption dependency mode of the team. Phase One of the realist evaluation was “done to” participants and continued to reinforce the basic assumption dependency mode,

experienced as passivity, hostility and the projection of power to act onto me as the researcher. Phase Three findings included the basic assumption dependency mode operating as a social defense against the pain of learning from difficult experiences, and against feelings of loss, particularly in relation to the patient care errors that had led to the organization development intervention.

Phase One identified an alternative psychological mechanism that operated within the team dynamic, which was reported as occurring in clinical world constructions when a patient was present. In this context, the team operated in work group mode, which produced supportive teamwork, enjoyment at work and participants were empowered to act as individuals. This finding led me to reconsider the methods of data collection and analysis for the realist evaluation in Phases Two and Three, which led to the findings about the second research question. The findings in relation to the first research question are summarized in figure 6.4 below.

<b>Micro-contexts</b>	<b>Psychological Mechanisms</b>	<b>Relationship Outcomes</b>
Special measures intervention in response to errors in patient care	Basic assumption regression from pain of learning from experience and from feelings of loss Oppression	Participants splitting from colleagues and patients Disempowerment & negative feelings about work
Participant social world constructions in a team in difficulty	Basic assumption dependency mode	Hostile team relationships & negative feelings about work. Projection of power to act onto team leader.
Participant clinical world constructions in a team in difficulty	Work group mode	Supportive teamwork & enjoyment. Empowered to act as an individual
Realist evaluation "done to" participants	Basic assumption dependency mode	Participant passivity, hostility and projection of power onto researcher

**Figure 6.4 Summary of Contexts, Mechanisms and Outcomes in relation to first research question**

## ***2. How do collaborative change processes engender culture change in the context of teams in difficulty?***

Phases Two and Three of the project focused on creating contexts that would foster collaboration between participants with a view to generating a wider experience of the team in work group mode such that this would create a virtuous spiral of positive experiences and relationships at work. Phase Two began with the new Senior Manager framing her position in relation to the team by overtly distributing leadership to them as individual professionals, and providing a focus on patient-centred service improvement activities. This led to group identification with her as a leader and active followership behaviours. Subsequently, the deputy Senior Manager and participant, Caroline, drawing on findings from Phase One, led a group discussion about change and loss, which generated group ownership of feelings of loss and the beginning of an emotional working through of their grief in relation to the patient who had been harmed by the serious clinical incident, and the anger and confusion caused by the resulting organization development intervention. My ownership of feelings of doubt, use of the poetic process and a generative metaphor in the same group discussion led to trust and reciprocity being built between participants and myself. In this way we began to provide psychological containment for the team process.

Findings in relation to appreciative inquiry were that it generated within and between participants the integration of split off positive aspects of self, other and team. It resulted in positive and productive teamwork being acknowledged as deeply important to individual participants. The appreciative inquiry was carried out with and by participants so that they were empowered to evaluate individual and group strengths leading to experiences of work group mode in a non-clinical situation. The discovery and action dialogue led to similar findings that a closely structured affirmative dialogue within a group setting created containment and psychological safety, which resulted in diminished power differentials, sharing of multiple viewpoints and a natural building of consensus. The discovery and action dialogue led to a further finding that it provided an emancipatory context in which participants found the freedom to connect with their animating purpose at work: relationships with patients for whom they cared. Through reflecting on pleasurable learning experiences and feelings of relatedness the team generated their own evaluation of what worked well for them and how they wanted to build on their strengths in the future. This led to team integration, co-operation, equality of voice, catharsis, recognition of interdependence with colleagues inside and outside the team, and with



patients. The findings in relation to the second research question are summarized in figure 6.5 below.

<b>Micro-contexts</b>	<b>Psychological mechanisms</b>	<b>Relationship outcomes</b>
Team workshop led by senior manager distributing leadership and focus on patient-centred service improvement	Group identification with the leader	Leadership-followership co-operation & work group mode
Group discussion using appreciative methods, ownership of feelings of loss and doubt, poetic process, generative metaphor.	Containment	Trust and reciprocity between practitioner-researcher and participants & between participants across social boundaries
Appreciative inquiry Interview	Integration of split off positive aspects of self, other and team	Positive and productive teamwork acknowledged as important to self and others
Realist evaluation "done with" and by participants	Work group mode	Participants empowered to evaluate individual and team strengths
Discovery and action dialogue using 1-2-4-All method	Containment and psychological safety created by structure Freedom to connect with vital developmental task of work group mode Work group engagement with pleasurable learning from experience and with feelings of relatedness	Diminished power differentials, sharing of multiple viewpoints, natural building of consensus Team integration, co-operation, equality of voice, catharsis, interdependence with colleagues and with patients

## **Figure 6.5 Summary of Contexts, Mechanisms and Outcomes in relation to second research question**

### **Limitations of methods and design strategies**

I do not know whether my reframing of the interview data into active and constructive themes in Phase One was experienced as silencing or devaluing of participants' views. Grant and Humphries (2006) and (Onyett, 2009) caution against mistimed use of positively framed interventions without acknowledging the pain of difficult experiences. I had a useful discussion with Kate who told me that I had missed two of her themes about a lack of communication and leadership. I found that it was important to explain my thinking to her about deficit-based cycles of communication in the team and the need to focus on what was working rather than not working. I believe that she had felt misunderstood and devalued, and that the conversation reassured her that I had heard and valued her views and that my decision to reframe the themes was in response to her and other participants' frustration and distress.

This discussion helped me to formulate my presentation to introduce the appreciative inquiry to communicate to other participants that I was not dismissive of their feelings of anger, hurt and distress. I acknowledged the negative feelings that had been expressed by team members whilst explaining how appreciative inquiry could support them in creating a positive future together. Caroline's use of Kubler-Ross's (1969) model of the stages of grief ensured that the team's emotions in relation to loss and change were acknowledged as natural and understandable which led to a significant discussion about how long it would take for them to feel better. I was aware that I needed to acknowledge the failure and hurt felt and to move into creating a space that valued experience as a generative resource (Grant and Humphries, 2006, Bushe, 2010). I believe that appreciative inquiry was supportive for this team because I had heard and acknowledged their deficit cycle and chose to offer a different more hopeful option for learning and relating with me and with each other.

The two porters and three administrative staff chose not to participate in the evaluation project, which means that none of the voices and perspectives of these groups of staff were represented. The project may have increased any pre-existing split between these team members and their professionally qualified colleagues, and left them feeling isolated. However, their inclusion in the model created by the

discovery and action dialogue suggests that team members who participated held them in mind and narrated them into the team.

Raising similar questions about the emancipatory and democratic nature of the project, only the team leader, John, undertook the appreciative inquiry interviews with colleagues. Arguably, he had the most to gain from the exercise as it legitimized his position in the team and it may have been disempowering to the other two pilot appreciative inquiry participants. However their participation in the discovery and action dialogue suggested that they remained engaged with the project. There may not have been sufficient psychological safety for Paul and Kathryn to carry out appreciative inquiry interviews with their peers.

### **Summary**

The discovery and action dialogue deepened my understanding of the way that appreciative methods used within a carefully designed structure can facilitate team connection and engagement with their shared animating purpose and with each other. Using narrative resources that they had generated between themselves, the team created a new collective narrative. In my view culture is a product of stories told and the stories told in this hour were hopeful and joyful. Cultural norms are sustained by repeated patterns of conversation, and I do not believe that this discovery and action dialogue changed the culture. However, the project supports Bushe and Kassam's (2005) view that many micro-narratives are needed to change a macro-narrative, and each appreciative micro-narrative will have contributed to an experience of appreciation and support that participants identified as so important to feeling that work was a positive experience.

Reviewing the refined context-mechanism-outcome configurations in relation to the research questions has confirmed that an expert-led organization development intervention using a problem solving approach did not work for participants in this context. The intervention reinforced the basic assumption dependency that emerged in response to the psychologically threatening context of special measures in light of the serious clinical incident. Containment for the feelings of anxiety was provided by the leadership styles of the senior manager and her deputy who were able to enter the normative/emotional discourse of the team by recognizing the change and loss that the team had experienced and appreciating the expertise held within the team. The collaborative inquiry approach to the evaluation created micro-contexts of psychological safety that allowed work group mode to emerge and for participants to

evaluate and develop the aspects of their work that they valued. Study limitations were outlined and considered. The findings will be explored in more detail in the next chapter.

## **Chapter Seven: Weaver's knot – used to re-tie broken warp threads in weaving - discussion**

*“For without this belief in the mediation of knowledge to inform fragile ideals of ‘rational’ dialogue, practice and moral action in the face of organizational complexity, risk and uncertainty, all our human aspirations for change may lose their vital centre of gravity: the hope that we can make a difference.”*  
(Caldwell, 2005, p111)

### **Introduction**

In this chapter the threads of the research are drawn together and interpreted in the light of the literature reviewed and the scope of the research questions. In answering the realist evaluation question of what works, or does not work, for whom and how, I undertake a critique of my original organization development intervention and the theoretical assumptions underpinning it. This leads to a conceptualization of team deficit and appreciative cycles based on the context-mechanism-outcome configurations proposed by the project, and an exploration of the accompanying leadership-followership dynamics. I discuss the collaborative change processes that led to psychological safety for the team in this case and offer a framework for development practice with teams in difficulty.

### **Critique of the organization development intervention**

I designed the original organization development intervention using a conventional problem solving approach of diagnosis and intervention using a variety of developmental tools and techniques. The findings of the realist evaluation in relation to the first research question suggest that this intervention did not work for participants. They experienced it as oppressive and unsupportive of their change efforts. At the time, I believed that involving staff members in the diagnosis and design of the intervention offered them the opportunity to influence its direction. There was a gap between my espoused emancipatory position and the disempowering effects of my actions. In practice, I implemented a rational and linear plan to improve teamwork as a variable in the socio-technical tradition. Team members had little influence over the teamwork definition or improvement plan:

*“choice is reduced to participative methods of group learning towards a predetermined end, which is set by the change agent”* (Caldwell, 2005, p89)

I created a subtle disempowerment by offering diagnostic and intervention tools and techniques in an objective neutral manner. I was strongly influenced by the theory of process consultation (Schein 1999), which suggests that practitioner is both involved with and detached from her subjects and diagnostic tools:

*“Just as every interaction reveals diagnostic information, so does every interaction have consequences both for the client and me. I therefore have to own everything I do and assess the consequences to be sure that they fit my goals of creating a helping relationship.”* (Schein, 1999, p17)

This neatly sidesteps issues of power: the expert rhetoric and vested interest inherent in the position of the change agent, manipulative dynamics in group processes and in the coercive and political aspect of power relations in organizational processes (Caldwell, 2005).

*“In much of OD practice, consultants bring “new ideas” in the form of knowledge, tested by practice and research, into the client system so that the focus is more on implementing externally validated knowledge than on creating internally generated knowledge.”* (Bushe and Kassam, 2005, p164)

In this case, team members' own expertise was sidelined and undermined, as I assumed powerful change expert knowledge and positioned myself as their helper. In addition to my codified knowledge/power, I, alongside the team's external managers, justified our power by framing ourselves as champions of patient safety. It was easy to deny the choice and autonomy of staff in the face of the guilt they felt about the serious clinical incident, and the shame of being subject to an investigation and intervention. I attempted to facilitate open and honest conversations, which were not possible as staff members were not autonomous; they did not have a choice about whether to participate, and the role of hierarchy was left unexplored. I had believed that introducing a codified discourse of teamwork, in the form of the Aston Team Performance Inventory, would flatten the hierarchy. A deeper and explicit exploration of the practice context would have helped me empathize with the team experience (Brown and McCormack, 2011).

The situation review and situational analysis employed in this evaluation allowed me to consider the situation in its complexity including my part in it. I was then able to adjust my view of this complexity and to represent this to managers and team

members. I narrated myself fully into the discourse with them. Before this contextualization, change occurred in spite of my and other external involvement, as team members experienced oppression and they organized a level of self-help in response. Meaningful change was experienced as coming from their own efforts. This evaluation study provides a view into the reality of intervening to change a team's interpersonal processes and supports the following argument:

*“McDonald (2004) has argued that efforts by policymakers and senior managers to construct and manufacture types of interaction between professionals may not be successful as such types of practice need to emerge in a more organic fashion, in response to a perceived need for change at the local level. Further theoretical and empirical work is needed to better understand how different forms of interaction are constructed across different clinical settings, and the implications of this for interprofessional relations and patient care.”* (Lewin and Reeves, 2011, p1062)

There was collusion between a managerial need for performance to improve and my need to justify my role as change agent by taking responsibility to find a solution to the team problems. This supports the appreciative inquiry position that focusing development efforts on problems will magnify and reproduce problems (Cooperrider and Whitney, 2001) thereby reinforcing the original diagnosis that an intervention was needed as the problems were worse than originally perceived. I now see that “vocabularies of deficit” create polarity, social hierarchy and reduce the space available for generative conversations (Ludema et al, 2001). The team was allowed out of special measures when its performance had improved in line with organisational expectations. The rhetoric of improving working lives was swept under the carpet once this was achieved.

### **Conceptualizing a team in difficulty: knotworking and not-working**

Contemporary teamwork theory conceptualizes teams as dynamic, adaptive systems. The findings support the concept of team emergent states that are fluid and dynamic, and which are both outcomes of and inputs into team process (Marks et al, 2001, Burke et al, 2006, Weaver et al, 2013). This project contributes a detailed case study of the socio-psychological factors that give rise to team emergent states and the evolution of team functioning over time (Finn et al, 2010b, Weaver et al, 2013). I have conceptualized the micro-contexts and psychological mechanisms that gave rise to a variety of team emergent states in this case using Bion's theory of

group dynamics. These properties of team experience are states rather than traits suggesting flexibility rather than intransigence:

*"We choose to consider these variables emergent states rather than "traits" because of their mutable qualities. A trait is "a relatively enduring characteristic" (Kerlinger, 1986: 453) that has an air of permanency, whereas states are more fluid and more easily influenced by context. Some emergent states vary frequently, even in fairly short periods of time."* (Marks et al, 2001, p358)

Most models of teamwork focus on defining generalized characteristics of team effectiveness. This case offers a view that a team can experience changing emergent states of team effectiveness and ineffectiveness according to socio-psychological, temporal and contextual factors. I propose that the discursive construction and reconstruction of team emergent states will contribute to team learning and cultural norms over time. This suggests that close attention to contextualised discourses in each specific case is an essential part of any team development intervention.

This case also challenges the view that teams with a stable team identity over time will counteract the professional faultlines that may occur (Jehn et al, 2010). The findings support the proposal of Engestrom et al (1999) that concepts of stable teamwork and team identity are not applicable to acute healthcare settings. They conceptualize professional collaboration in acute healthcare as "*knotworking*", arising from complexity and fluidity of the settings in which professionals tie, untie and retie strands of activities with different professionals in short-lived episodes. Providing a counterpart to the concept of "*knotworking*", a concept of "*not working*" helped me to consider what happened in this case.

Like Armstrong (2010), I believe that basic assumption and work group mode are dual psychological states that co-exist which are called forth by different micro-contexts. They do not exist as a dichotomy, an either/or proposition, but both/and, just as individual and group identity co-exist and are intertwined psychologically, so are basic assumption and work group modes. The boundaries between basic assumption mode and work group mode were shifting and temporal according to context rather than static, and as such were dependent on the knots that were being



tied at any time by the discourse in operation. This offered the hope that defensive group processes could be changed if the discourse was changed.

In this team, the dominant internalized experience and externalized projection of the team was its basic assumption mode of dependency, which was experienced as “*not working*”. The team projected an idealized omnipotence onto its designated leader, becoming hostile when the leader was perceived to fail. I experienced a similar idealization and hostility as a projective identification with the basic assumption of dependency. I had become part of a parallel psychological process through which:

*“an individual’s thoughts, feelings, and actions reflect not only intra-psychic processes but also the conditions of the groups of which the individual is a member and the relations between those groups and others in the containing system.”* (Clarke Sullivan, 2002, p381)

Projective identification is a way of getting rid of unwanted feelings but also of seeking help. It is a primitive defense mechanism that is called forth by anxiety. Professional and other faultlines in healthcare teams emerge under stress, which can be caused by many contextual factors, and by the very nature of caring for sick and dying patients (Menzies, 1960). These faultlines, or splitting to use the Kleinian term, mean that psychological safety is lost and the conditions for groupthink and moral inaction are created (Gino and Moore, 2013). The discourses within and outside the team produced and reproduced the basic assumption of dependency. Figure 7.1 adapts Lewin and Reeves (2011) model of front, backstage and off-stage interactions, based on the original work of Goffman (1963) on impression management, modified by Sinclair (1997), to show the different settings in which professional relationships were enacted in this case.

	PLANNED	AD-HOC
FRONT STAGE	Clinical procedures – operations, scans Teaching in clinical environment	Interaction with or in front of patients in non-clinical areas
BACK STAGE	Morning briefing MDT Teaching in non-clinical	Corridor conversations Coffee room conversations Conversations with managers and

	environment Service improvement workshops Team building sessions Appreciative Inquiry Discovery & Action Dialogue	other colleagues external to the immediate team. Conversations with practitioner- researcher
OFF-STAGE	Christmas Party Retirement Party	Social relationships outside work

**Figure 7.1 Settings of team interactions after Lewin and Reeves (2011), after Goffman (1963)**

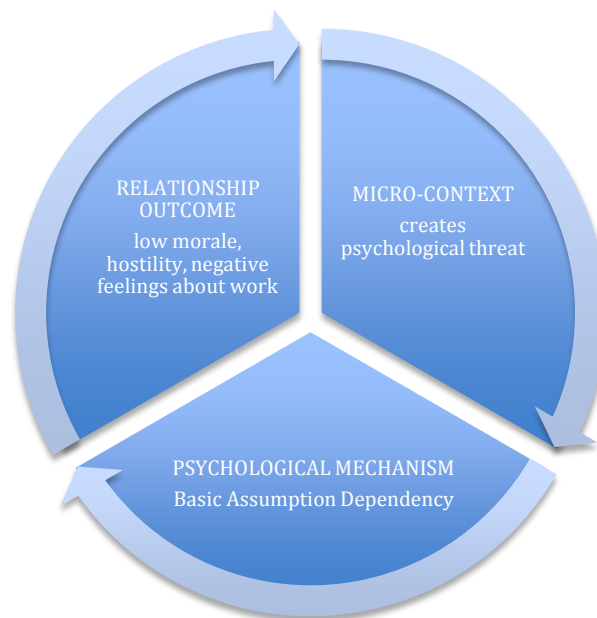
The findings from this evaluation suggest that the team was operating in work group mode in its front stage, action phases which were reproduced as discursive clinical world constructions; the team operated in basic assumption mode in its back stage, transition phases and off-stage, which were reproduced as discursive social world constructions. Team backstage space and time is vital as it provides the opportunity for reflexivity (West, 1996) and double-loop learning (Argyris and Schon, 1978) which are key to improving professional practice. Psychological safety is imperative for team learning to take place (Edmondson, 1999). Team members were unable to trust colleagues sufficiently to take interpersonal risks in both planned and ad-hoc back stage settings. Without psychological safety, I suggest that this team entered basic assumption mode as a self-protective defense. Operating in basic assumption mode limited each individual's range of choices in engaging freely and morally in team reflexive processes, thereby undermining professional autonomy and practice.

As the organization development intervention took place in the back stage social world space, it reinforced basic assumption mode and the emergent team state of low morale, hostility towards colleagues and negative feelings about work. The study supports Jones and Jones' (2011) finding that individuals experience teamwork as an emotionalized by-product of working closer as a group, and contributes a finding that poor teamwork is experienced as an emotionalized by-product of an absence of working closely as a group. Thus teamwork can be conceptualized as an emergent state linked to psychological safety rather than a distinctive form of interaction, or abstract managerial construct. An emergent state of enjoying working with colleagues, "*knotworking*", reproduced itself in the discourse of this team as organic and expressive of shared psychological safety, which was symptomatic of work

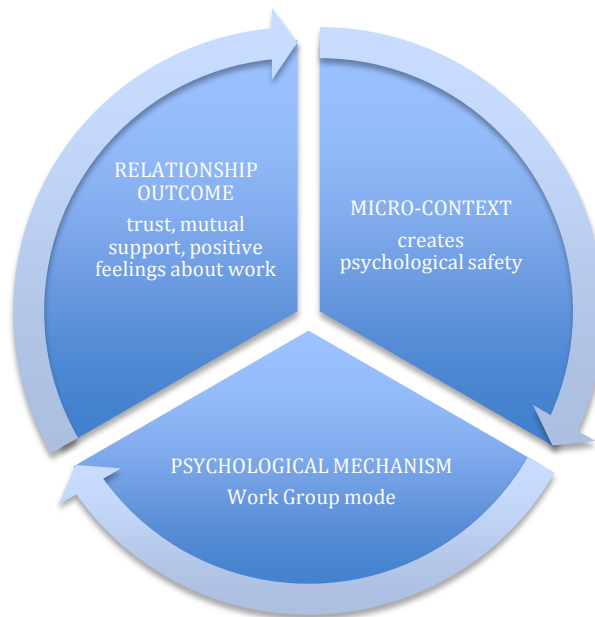
group mode. Similarly and simultaneously an emergent state of hating working with colleagues, “*not working*”, reproduced itself in the discourse of this team as organic and expressive of a shared experience of psychological threat, which is symptomatic of basic assumption mode. This suggests that the emotionalized by-products of this team improved through experiencing increased group psychological safety, thereby allowing the group to learn and reflect together on its developmental tasks:

*“Reliable performance may require a well-developed collective mind in the form of a complex, attentive system tied together by trust.”* (Weick and Roberts, 1993, p378)

The team was able to perform in the front stage space but struggled to learn and reflect together in the back stage space, which, in turn, limited its performance in the front stage space. The collaborative appreciative inquiry of phases two and three of the evaluation promoted psychological safety, which led to an experience of group learning and reflection in the back stage space. I have conceptualized a team deficit cycle (figure 7.2) and appreciative cycle (figure 7.3) drawing on the context-mechanism-outcome configurations emerging from the evaluation.



**Figure 7.2 Team deficit cycle “*not working*”**



**Figure 7.3 Team appreciative cycle “*knotworking*”**

### **Leadership and followership in teams in difficulty**

This case study contributes to the debate about leadership and the less researched phenomenon of followership in the NHS. Team members’ stress and anxiety from repeated negative experiences at work contributed to a search for somebody to take care of them in the position of an all-powerful parent. Grint and Holt (2011) describe this followership position as a romantic belief in a heroic leader and a denial of responsibility, which is similar to basic assumption dependency. They argue that levels of anxiety during times of change are likely to reduce follower engagement and encourage disinterested compliance. Using their typology of followership, I suggest that the team experienced less anxiety in the front stage clinical setting because professional hierarchy was clear in this domain, and they perform a technical followership function in response to a calculative-rational task. To pursue the “*knotworking*” metaphor, the knots that need to be tied between team members in the clinical domain are generally clear and directed, or commanded in an urgent situation. Lyndon (2007) found that the clarity of the clinical situation contributed to paediatric nurses’ confidence and agency, whereas they were less likely to challenge in less straightforward situations. Outside the clinical domain, back stage, the team entered the normative/emotional and more uncertain domain of collaborating to evaluate, plan and develop their service, which was experienced as “*not working*”. Team members became chronic followers and refuseniks (Grint and Holt, 2011) in the back stage space, rather than responsible followers. Contemporary leadership-followership discourse in healthcare is rooted in the industrial revolution master-

servant structure (Grint and Holt, 2011) and traditional hierarchical notions of professional bureaucracy (Finn et al, 2010b). In the original organization development intervention I attempted to move the team to a distributed model of leadership, flattened hierarchy and teamwork using cognitive methods, which did not work. I believe that it undermined the team further by creating inaction through the absence of familiar decision-making mechanisms. Huffington et al (2004) suggest that removal of traditional structures and concepts has the potential to create tension and anxiety:

*“that can significantly reduce the mental space, within the individual and/or the group, available for generativity in decision and action which the transition to a distributed model is designed to promote”* (Huffington et al, 2004, p78)

Paradoxically, a leader with positional authority can contain this anxiety through articulating a vision and providing a transforming metaphor. This allows the traditional leader-follower dynamic to become more flexible (Huffington et al, 2004). Grint and Holt (2011) propose that complex problems require individual leaders to hand over authority to the collective of responsible followers:

*“Leadership...the art of engaging a community in facing up to complex collective problems.”* (Grint and Holt, 2011, p11)

In this case, the new senior manager and deputy manager provided adaptive leadership through their ability to engage the team in a normative/emotional discourse by acknowledging and appreciating their history, their expertise and their aspirations and by engaging them in meaningful activity relating to their own care for patients. This gave permission and support for the team leader to take the interpersonal risk to become an adaptive leader within the team and to engage them in the appreciative inquiry and discovery and action dialogue. As micro-contexts of psychological safety were created, team members became responsible followers and participated actively and constructively in creating the back stage narrative.

The leadership provided by the new senior manager and her deputy support the findings of McCormack et al's (2013) realist review of change agency in healthcare. The review found that successful change agents have a positive attitude, respect, accessibility and credibility and a match with the age and professional skills of the team. The senior manager demonstrated an ability to positively influence the micro

and meso context of the team, in particular the perception of the team by others within the organisation. Both she and her deputy were protective of and actively engaging with the team. McCormack et al (2013) identified that potential overlap between the mechanisms of actions between change agents and leaders was worth exploring. This case study suggests that change agency is a shared property of the leadership-followership dynamic. When the leadership-followership dynamic was shaped by basic assumption dependency then there were few possibilities for team learning and, as a consequence, change. When the leadership-followership dynamic was shaped by work group mode, then team learning was facilitated and change agency was distributed to all team members.

### **Collaborative change processes that engender group psychological safety**

Given the importance of psychological safety to a team's ability to operate in work group mode, this section considers the collaborative processes that created the conditions for the team to move from experiencing group psychological threat in its backstage interactions, to psychological safety. The findings suggest that the team changed in the direction of the evaluation, and that intervention and evaluation were two sides of the same change process from the beginning of external involvement. When the initial organization development diagnosis (a form of evaluation) and intervention were "done to" participants using a problem solving approach, this created oppression and reinforced basic assumption mode. The data supports Cooperrider and Whitney's (2005) assertion that problem-solving approaches to change generate defensiveness. I focused on the elements in the team that were experienced as "*not working*" rather than identifying and building on the elements in the team that were experienced as "*knotworking*".

When the evaluation was "done with" participants using collaborative, appreciative inquiry and discovery and action dialogue methods, this generated a series of communicative actions between participants (Grant and Humphries, 2006), which led to psychological safety and work group mode. It is rare for programme and evaluation to develop simultaneously despite it being recommended as best practice (Sullivan, 2002). Evaluation can be used for judgement or learning (Guba and Lincoln, 1989): in the original intervention it was used for judgement, and in the research project for learning. The movement from judgement to learning was critical in opening up space for connection to the team's animating principle and practices (Armstrong, 2010).

In this case, a traditional evaluation approach (the semi-structured interviews carried out by researcher) led to a different construction of reality than the appreciative inquiry approach (appreciative inquiry interviews carried out by researcher and participants). The traditional evaluation approach disempowered participants and empowered the researcher, whilst the appreciative inquiry approach empowered participants and removed the expert power of the researcher. The appreciative inquiry interview challenged the normative thinking and feeling patterns and dialogue of participants. They reported that it was both challenging and helpful to think about the appreciative inquiry topics. Having seen the three pilot interviewees struggle to identify three wishes, I asked if they wanted to change this element of the questionnaire. All three participants wanted to keep the final three wishes question in the interview protocol as they said it made them really think hard. By contrast participants found it easy to discuss what didn't work well in the semi-structured interviews.

This indicates that appreciative inquiry operated as a method of critical inquiry by challenging normalized belief systems that oppressed participants. Appreciation may mean to know, to become conscious, to take full or sufficient account of something (Grant and Humphries, 2006). This is vital to evaluation practices with teams in difficulty. Appreciative inquiry encouraged team members to develop reflexive abilities in order to value what was important to them and their colleagues. Appreciative inquiry and the discovery and action dialogue expanded team members' collective circle of moral regard (Gino and Moore, 2013) such that this extended beyond immediate professional colleagues to include non-professional team members, external teams and patients. The purpose of critical forms of inquiry is to liberate internally subjugated perspectives (Caldwell, 2005). This appreciative inquiry liberated subjugated vital, generative individual and team experiences. In doing so, it also allowed the unspoken shadow of the team's experience into view.

The appreciative inquiry and discovery and action dialogue disrupted the normalized negative backstage interactions of the team. Using these methods, participants flattened their hierarchy and created reflexivity, reciprocity and relationality. Their choice to participate as group was a key indication that they felt psychologically safe, and could engage in work group mode. The previous group exercises, which I had designed to build trust, vision and values as part of the organization development intervention, had been experienced as unsafe, as reported in the semi-structured

interviews. The discovery and action dialogue built psychological safety because it invited participants to draw on their own stories as a resource.

Both appreciative inquiry and positive deviance employ oral narrative as a central device. Folk narratives such as stories and gossip are both constitutive and evaluative mechanisms of the shadow organization (Michelson et al, 2010). As Paul Bate discovered in an intervention in a UK hospital:

*“stories and storytelling are therefore not only crucial to establishing group identity; they are equally crucial to implementing change, especially cultural change”.* (Bate, 2004, p37)

Greenhalgh and Hurwitz (1999) highlight that narrative tells us how people (teller, listener and protagonists) feel about something, it constructs meaning and interprets experience. It is also a basic learning resource that all people have access to, which is memorable, grounded in experience and encourages reflection (Greenhalgh and Hurwitz, 1999).

Drawing on the work of Tsoukas and Hatch (2001), whilst groups are a feature of the social world, they also a feature of our thinking about the social world. Therefore the individual constructs of the “team” will alter the way that the “team” exists. Logico-scientific thinking about teams and teamwork, which dominates healthcare, is general, reasoned, theory driven and de-contextualised. Narrative thinking about teams and teamwork privileges individual experience, a plot, is contextualized, historical, and paradoxical. As Labov’s (2010) work on the construction of oral narratives of personal experience shows, the narrative mode places a particular focus on the evaluative component of assigning praise or blame. Keogh (2013) highlights how blame is easily called forth in discourse about healthcare errors or failures, rather than support and improvement. The act of narrating and listening are interpretive acts that take place in specific contexts, which inspire and support specific meanings (Tsoukas and Hatch, 2001). Narrative preserves time and human agency and constructs memory, and expectation, which extends time into the past and future. This enlarges our appreciation of the present. Appreciative inquiry explicitly invites participants to consider the generative aspects of their past experience and to carry these into their dreams for the future. In this case, it enlarged the context for participants to appreciate each other more fully in the present. By making connections between the past, present and future the collective mind – the pattern by which individuals heedfully interrelate their actions – is



strengthened (Weick and Roberts, 1993). By developing narrative skills a team becomes richer and more complex:

*“Stories organize know-how, tacit knowledge, nuance, sequence, multiple causation, means-end relations and consequences into a memorable plot.”*  
(Weick and Roberts, 1993, p368)

I suggest that the sharing of multiple stories of high points of team experience allowed participants to organize their tacit knowledge and know-how into a constructively memorable plot that gave the team confidence to move forwards autonomously. The positive motives of team members were surfaced in the plots of the stories that allowed individual and team motivation behind actions to be experienced as moral, good, and worthy. The discourse analysis and restorying of the appreciative inquiry data allowed me to highlight the narratives of praise that emerged so that the positive core of the team that was carried in individual stories could be reproduced and retold in the discovery and action dialogue.

The methods of the evaluation were simple and practical and could translate to any healthcare setting. The appreciative inquiry interviews and the discovery and action dialogue took few resources to set up and complete. The appreciative inquiry interviews all lasted less than an hour, and the discovery and action dialogue took one hour. The materials used were inexpensive, and it was located within the workplace. The participant-led appreciative inquiry interviews and the discovery and action dialogue all took place in the back stage setting of the department. This supports Cooperrider and Whitney's claim that *“problem-solving approaches to change are painfully slow”* (2005, p11). The original organization development intervention lasted eighteen months. Most published appreciative inquiry case studies involve a one or two day summit with large groups of employees. The shorter discovery and action dialogue was inspired by case studies from American hospitals (Singhal et al, 2010). This project offers a new perspective: the appreciative inquiry and discovery and action dialogue were organized and undertaken by a small front line team, without any external managerial input or top down large scale hospital change movement. The team owned the experience without the need to report outcomes or outputs. Bushe and Kassam (2005) found that reported effects of appreciative inquiry in a range of studies were more likely to be transformational if there was no formal or controlled action plan but employed a more improvised approach.

Through the clinical, patient-centred stories told in the appreciative inquiry and reproduced for the discovery and action dialogue, the team brought the psychological safety of the front stage space into the back stage space. This created psychological safety in a back stage space, which allowed the team to operate in work group mode and to evaluate, learn and plan together. This supports Bushe's (2010) findings that appreciative inquiry is transformational when it addresses problems that are important to organizational members through generativity, rather than problem solving. He also proposes that appreciative inquiry cannot magically overcome poor leadership, communication failure and unresolved conflicts. He suggests that it requires passionate leadership. I believe that the appreciative inquiry process allowed the team leader, John, to communicate his passion for his work generatively and to connect with the values and passion of team members, which created psychological safety and the emergence of work group mode in the discovery and action dialogue.

### **Framework for development practice with teams in difficulty**

Most team development methods in healthcare do not take account of the psychological position of a particular team or the interaction between a team and its contexts. Generalized and logico-rational models of teamwork suggest that instrumental methods can be applied to all teams with successful outcomes. This belief system is underpinned by a view that culture is a variable that can be manipulated.

This evaluation suggests that successful team learning is dependent on the interplay between macro, meso and micro contexts and the operation of the team's psychological mechanisms over time. If the micro-context is predominantly psychologically threatening then a team is likely to experience interpersonal difficulties, which reproduce themselves in a deficit cycle. Psychological threat in the micro-context may be created by discourses in the micro, meso or macro context or a combination of the same. However a review of reporting on medical errors showed that healthcare professionals focus predominantly on individual and situational factors that are proximal to the error rather than latent errors in the wider system (Lawton et al, 2012). This suggests that psychological threat is likely to be experienced and reproduced as caused by the micro-context and individuals within it. If a team spends its back stage time in basic assumption dependency mode then an intervention is likely to be experienced as initially offering salvation and then

oppressive and blaming, with blame reproduced intrapsychically and interpersonally. I offer the following framework for changing this dynamic for development practitioners, designated leaders, change agents and teams to consider.

### **Formative use of realist evaluation**

This project suggests that teams change in the direction that they inquire. This team experienced itself as “*not working*”, and was pursuing a deficit-based inquiry in its own folk narratives. Inevitably I became part of the problem as soon as I entered the dynamic. Therefore, a collaborative active and constructive framework for the evaluation was essential, through which participants generated a change in relationships through their own communicative actions (Habermas, 1985). I recommend that realist evaluation is employed as a formative framework to guide change processes with teams in difficulty. This supports emancipatory development. The emergent nature of realist evaluation suits the changing contexts and complex dynamics of specific healthcare environments and enables close scrutiny of micro-contexts, psychological mechanisms and relationship outcomes. It offers an on-going opportunity to check in with team members and to change course if the intervention is experienced by the team as “*not working*”, thereby avoiding a reproduction of the team deficit cycle. McCormack et al (2013) found that change agents underutilized theory in their interventions. Realist evaluation provides a theory driven methodology for identifying patterns and refining micro-theories to inform decisions and actions. I used the realist evaluation framework at the end of this project to synthesize and articulate the micro-theories that I had used in the evaluation. The evaluation would have been strengthened by the formative use of realist evaluation from the beginning of the project. The initial interview questions could have been formulated using realist interview principles (Pawson and Tilley, 1997), which may have avoided the reproduction of the team deficit cycle. This would have allowed me to understand more fully outcome patterns and different effects on different stakeholders before designing phase two of the project.

### **Containment: understanding patterns of transference and counter-transference**

The stance of people involved in change interventions is important to containing the anxiety that underpins any basic assumption mode. McCormack et al (2013) found that the success of change agents was predicated on how responsibility and accountability was established in the change agent role and their attitude to responsibility and accountability as well as establishing respect and being a role

model for the values and practices espoused. In this case, the power to resolve conflict was projected onto the leadership figures and my perceived expert power as nominated change agent. Containment is about allowing projections to exist without reproducing them in the counter-transference. The original organization development intervention reproduced the deficit cycle in the counter-transference. I reinforced the basic assumption transference in believing that I could solve the team's problems for them.

Drawing on the early psychoanalytic work of Ferenczi (1916), transference in everyday life can be defined as an individual's unconscious introjection of parts of the perceived world into their internal world, and projection of unwanted parts of their internal experience onto the external world. In processes of group conflict, the transference patterns of individuals cannot be negotiated satisfactorily in the external context and a pattern of psychological splitting into good and bad objects, to be praised and blamed, occurs (Obholzer & Roberts, 1994). Successful facilitation of teams in conflict is a function of a change agent's capacity to "*handle intense transference reactions*" (Czander et al, 2002, p 378). Phase one of the evaluation raised my awareness of the contexts that called forth and reproduced these defensive mechanisms. Recognition that everything in the situation conditions possibilities for action (Clarke, 2009) led to my understanding that change could be facilitated by the creation of a series of micro-contexts rather than a series of actions "done to" the team. As a result, I chose collaborative methods to create micro-contexts of psychological safety so that psychological integration could occur, and different perspectives and positions could again be acknowledged within the creation of a new collective narrative.

The issue of "fit" is important (McCormack et al, 2013). I was not a good fit for the team as I did not have a background of working in healthcare, and only had two years experience in the NHS at the time I began the intervention. Whilst I was an experienced practitioner in facilitating teams in a variety of other contexts, I did not understand the particular context within which I was working. Commissioning a generic representation of the situation from the team's discovery interviews provided an account of the deficit cycle. I accepted this as an objective truth rather than a defensive construction of aspects of social experience that projected the power to change the team experience onto others outside the team. Unconsciously, I colluded with the team to avoid the pain and uncertainty of change and learning: me from my inexperience in this context and they from their traumatic experience. The external

managers in charge of the team during the original intervention were professional managers by background, whereas the new senior manager involved in the evaluation had a clinical background similar to the allied health professionals so could understand their front and back stage context with ease. Therefore it is worth considering if people leading an intervention fit the team, and if not, how knowledge of the context is accessed to give a multi-faceted appreciation of the situation.

In psychotherapy, practitioners use clinical supervision to recognize and work through patterns of transference and counter-transference. Conversations with my doctoral advisers, organization development colleagues and an external psychotherapeutically trained supervisor brought into my awareness my unconscious acting out of the counter-transference in this project. This allowed me to feel contained, and to become and remain reflexive during the course of the research. My research diary and field notes helped me to narrate myself into the project. I recommend these methods and regular and frequent peer discussion and supervision for development practitioners or other change leaders involved with teams in difficulty. I experienced fear, anger, hatred and, most powerfully, deep shame because I felt unable to fix the team in the counter-transference. Without a range of supportive conversations and methods, these feelings were too painful to surface in the original organization development intervention.

I gradually moved out of this counter-transference using the methods of the evaluation that provided containment and “*conditions for growth*” which Boomer and McCormack (2010) identified as important to cultural shifts in the practice (care) setting. The conditions for growth that I experienced as a practitioner-researcher were also conditions for growth for the team: reflexivity, relationality and reciprocity. The methods and evaluation processes that related to a practitioner stance of reflexivity, relationality and reciprocity are outlined in table 7.1 below. This stance was core to containment of the counter-transference and allowed me to engage with the research process and participants creatively rather than defensively.

Team reflexivity has been conceptualized and researched particularly in relation to healthcare teams (West, 1996, Hoegl and Parboteeah, 2006). In this project I would argue that team relationality, the ability to see oneself in an equal relationship to others, and team reciprocity, to offer and acknowledge trust and support, emerged from the creation of psychological safety. These changes in team state allowed participants to engage in work group mode with the developmental tasks of the

appreciative inquiry and discovery and action dialogue. In particular, psychological safety was enhanced by the conscious removal of my role in the appreciative inquiry interviews, and in reducing my input to four questions in the discovery and action dialogue.

**Table 7.1 Realist evaluation framework for development practitioners working with teams in difficulty**

Practitioner Stance	Methods	Evaluation Processes
Reflexivity	<p>Create messy and ordered Situational Analyses</p> <p>Discuss personal experiences and responses to team dynamic in supervision.</p> <p>Keep a practitioner diary.</p> <p>Keep field notes.</p> <p>Construct and refine micro-context-psychological mechanism-relationship outcome configurations</p>	<p>Move beyond self as knowing subject to identify elements and discourses influencing the situation.</p> <p>Identify and understand constructive and destructive communication patterns.</p> <p>Identify if, when, where and what basic assumption mode(s) are operating and if, when, where work group mode is operating.</p>
Reciprocity	<p>Permit participant choice to participate or not.</p> <p>Provide an active and constructive response to events in the field.</p> <p>Share own reflexive processes with team members.</p> <p>Introduce and invite collaboration from team members in appreciative inquiry.</p> <p>Record negative transference in practitioner diary and take to OD supervision.</p>	<p>Value and amplify what is valuable to team members.</p> <p>Co-create micro-contexts of psychological safety.</p> <p>Practitioner narrated into the evaluation</p> <p>Contain anxiety &amp; invite reciprocity from team members.</p> <p>Build active and constructive communication patterns between self and team members.</p> <p>Raise awareness of positive emotions and constructive communication supporting individual and team resilience.</p> <p>Maintain own resilience and constructive energy.</p>

Relationality	Pilot appreciative inquiry interview protocol Invite team members to conduct individual appreciative inquiry interviews Re-story interview data Hold a workplace discovery and action dialogue using 1-2-4-whole method. Evaluate process and outcomes using appreciative inquiry six freedoms as a framework.	1-1 constructive narrative experiences between team members. Team members evaluate what works for them individually. Appreciative stories provide narrative reflection of self to individual team members. Share multiple individual constructive narratives in a team conversation providing a constructive collective narrative reflection to team members together. Team members evaluate collectively what works best for them and make decisions about what to do next on this basis.
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### **Making space for multiple narratives creates team reflexivity, reciprocity and relationality**

Given the contextualized, complex and temporal nature of the team, a range of narrative approaches allowed me to respond to the non-linear, contradictory and paradoxical nature of the team's discourses, constructed by and for them (Tsoukas and Hatch, 2001). By narrating myself into the evaluation in phase two I disrupted the power of the transference and counter-transference between the team and me. I told the team my story of our relationship, sharing my feelings of failure and doubt having reflected deeply on my part in their lives, and introduced a humorous poem as a counterpoint to feeling stuck in a rut. In doing so, I acknowledged my purposes and motives for working with them in the past and how I wished to collaborate with them in future in particular by discovering the best of what was, to dream and to create with them. I used my personal story to bring about dialogic and reciprocal exchange (Arranda and Street, 2001). I invited participants to tell their stories to me and to each other in the appreciative inquiry, and gave them freedom to generate the narrative of the evaluation. I took the psychological risk to speak about my own perspective and doubts about what to do and indicated that it was psychologically safe for them to do so too. In the same workshop, the senior and deputy team managers narrated themselves personally into the team narrative using their personal and professional voices. The back stage space became a place that we all

inhabited in a more meaningful and open-ended narrative (Tsoukas and Hatch, 2001).

I found that the creation of multiple individual narratives and using these as the basis for creation of group narratives allowed multiple perspectives to become visible. This created a context of psychological safety for team members to be comfortable to be seen as themselves in terms of their own narrative. In not looking for consensus, differences and contradictions were encouraged with *“the potential to be a rich tapestry of understanding that becomes an impetus to further inquiry”* (Arranda and Street, 2001, p795). The choice of an active and constructive narrative position facilitated a cultural exploration of commonplace but obscured notions about oneself in relation to the team. Language was the main cultural resource accessed. The narrative act drew out consciousness in a biographical frame. It brought new conceptual depth to the team experience that operated as a corrective emotional experience and activity of therapeutic restoration. One of the stories generated by the appreciative inquiry provided a narrative counterpart to the serious clinical incident as it involved the same staff in the same setting. Their narratives provided an opportunity for participants to reflect on taken for granted assumptions about work and to understand how their meanings, motives and values influenced how they engaged with each other and their patients (Arranda and Street, 2001).

## **Summary**

In this case, conventional problem-solving approaches to team development were found to reinforce existing patterns of deficit relating which led to a critique of organization development practice. Building on the theoretical work of Engstrom et al (1999) and Lewin and Reeves (2011), I have proposed a reconceptualization of experiences of teamwork as emergent states of *“knotworking”* and *“not working”* using context-mechanism-outcome configurations. I have explored the different front stage and back stage enactments of teamwork, and proposed that these different contextualized experiences had different effects on the learning behaviour of the team and on the leadership-followership relationship.

The collaborative, active and constructive methods of the project engendered psychological safety for participants and allowed them to evaluate their own experiences of successful teamwork and to incorporate multiple perspectives into their collective narrative. The narrative and appreciative methods of the research functioned as emancipatory approaches. I have proposed a framework for



development/evaluation practice with clinical teams in difficulty which recommends the use of situational analysis, formative use of realist evaluation, a practitioner stance of reflexivity, reciprocity and relationality and using narrative methods and critical appreciative processes to create team reflexivity, reciprocity and relationality. Overarching conclusions and recommendations are included in the next chapter.

## **Chapter Eight: Double overhand stopper knot – acts as a stopper in the end of a rope, and can also be used to increase the security of another knot - conclusions and recommendations**

In this chapter, I set out my conclusions and recommendations situated in the current NHS context. I identify that critical appreciative development processes create psychological safety within which NHS staff can reconnect with their animating purpose at work, which is generally related to patient care. I provide a critical analysis of the call for methods to measure cultural health in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) and propose a practice model of creating a critically appreciative space, as a personalised approach to understanding and supporting teams in distress. I recommend further research into narrative methods of team development in healthcare that focus on relationships with patients. I conclude the chapter with my reflections on the evaluation strategy, and my doctoral learning.

In his recent review into the quality of care and treatment in fourteen hospital trusts in England, Sir Bruce Keogh (2013) identified some common barriers to providing high quality care:

*“the limited understanding of how important and how simple it can be to genuinely listen to the views of patients and staff and engage them in how to improve services. For example, we know from academic research that there is a strong correlation between the extent to which staff feel engaged and mortality rates....*

*the imbalance that exists around the use of transparency for the purpose of accountability and blame rather than support and improvement” (Keogh, 2013, p4)*

The findings of this project suggest that listening to and supporting members of staff to improve services, particularly in a demoralized climate when there have been serious errors or failures for patients, can be a problematic process for those intervening. Keogh (2013) notes that patient and staff focus groups were the most powerful method of “*getting under the skin*” of organizational culture, rather than a technical exercise involving rigid tick-box criteria. Together with the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013), the Keogh report has created a political sea change in accepting qualitative evidence, in particular patient

and staff stories, as a valid source of information about what happens in healthcare. This provides a springboard for reconsidering ways of conceptualizing, improving and evaluating teamwork beyond the accepted norm of rational-instrumental methods of training and tools.

### **Critical Appreciative Processes**

The project employed appreciative inquiry and positive deviance methods to discover participants' subjugated tacit knowledge. This narrative knowledge provided a generative resource for the team. Critical appreciative processes (Grant and Humphries, 2006) are not about positivity per se, or ignoring problems, but about using internal expertise generatively in an emergent and complex situation. Participants used these methods to confront norms, narratives and power relations in this team within a micro-context of psychological safety (Onyett, 2009). This micro-context invited the team out of its defensive patterns to focus on the deeply held moral purpose that each held for their work and the team. I agree with the view that appreciative inquiry sits within the critical paradigm linking to Habermas' concept of communicative action, and to Paulo Friere's concept of conscientisation leading to adult development (Grant and Humphries, 2006).

### **Patient care as an animating principle for healthcare teams**

This evaluation project offered the opportunity to examine the factors that led to loss of sight of the shared goal of patient safety, resulting in the absence of collegial trust and mutual respect within a team. The absence of collegial trust and mutual respect meant that, at times, conflict could not be successfully mediated. It emerged from the project that relationships with patients were a source of deep joy, satisfaction and pride for participants. When they were with or held their patients in mind, team members' ability to appreciate and support each other came to the fore. Generally patients are understood as the recipients or subjects of clinical teamwork in healthcare teamwork models. In this case, relationships with patients were part of the "*knotworking*" experience for participants, rather than passive recipients of care. Noticeably the team's experience of "*not working*" was when patients were absent. It was as if relationships with patients either in reality or in memory operated as reminders of participants' higher, moral self. When experiences with patients were actively incorporated into discussions about teamwork this created a micro-context for the team to move into work group mode.

The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) suggests that the dehumanization of staff and the dehumanization of patients were closely linked. It was striking that participants telling stories about high point experiences with patients was generative for them. What this revealed to me was that I hadn't heard stories about when things hadn't gone well with patients. The serious clinical incident experienced by members of this team remained in the shadow culture of the team, and may have benefited from an appreciative inquiry in seeking to understand how team members used their resources and relationships generatively at the time or following this incident (Onyett, 2009). This emerged in the margins of the project and is an area that would merit further research with other teams that have experienced a serious clinical incident.

The project suggests that focusing on staff narratives of experiences with patients provides a powerful generative and regenerative resource for team development, particularly for teams who have experienced difficulties. An area for future practitioner research would be to include patient experience stories as a component of evaluation processes with teams in difficulty, or to include patients as stakeholders in a case study of clinical team development in order to add the dimension of what works (or does not work) for them, in what circumstances and how.

### **Contribution to Practice**

Realist evaluation offers a methodology for understanding the complex interplay of contexts, mechanisms and outcomes at micro, meso and macro levels. As such it offers a valuable approach in helping development practitioners to evaluate formatively how components of their change interventions interact with contexts and underlying mechanisms to produce outcomes. In this project, a range of evaluation methods based on appreciative inquiry and positive deviance approaches created micro-contexts of psychological safety and more constructive and emancipatory relationship outcomes than a traditional organization development approach. I recommend that evaluation and intervention are collapsed into the single approach of collaborative inquiry whereby expertise is seen as resting in the hands of team members. Internally generated knowledge is used to discover what works and is built upon, rather than externally proposed theoretical models of team communication and behaviour. This is likely to generate more rapid, enjoyable and complex learning experiences than an expert generated teambuilding or training intervention. Such an approach requires an organization context in which democratic and participatory approaches to cultural development are valued and promoted. In

contexts where command and control management structures maintain a rigid power hierarchy this approach is unlikely to work, and may disempower frontline staff. Therefore, development practitioners must consider and seek to influence their organization context to create an overarching participative approach to culture change in which the empowerment of frontline staff is a genuine goal.

Routine assessment and monitoring is central to NHS governance practice and I agree that standards of practice should be clear, monitored and reported. However measuring cultural health, whilst called for by The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013), cannot be achieved by the application of tick box tools. McSherry et al (2013) recommend a cultural health check model for use by staff to escalate concerns. However, the model does not take into account the dimensions of psychological safety, professional and organizational power dynamics or the leadership-followership relationship in producing cultural outcomes. I would argue that the cultural health check model is appropriate for checking standards but may act as a “*culturally inhibiting factor*”, to use McSherry et al's (2013, p13) term, if used to evaluate cultural health. It treats culture as a variable subject to managerial control, which has the potential to create a psychological threat for teams in difficulty. I recommend an alternative approach to cultural evaluation that is critically appreciative, invites multiple voices to be heard and responds to the temporal, contextual and emergent nature of teamwork. In order for cultural evaluation to be democratic and of value to staff and patients, NHS Trusts could introduce simple methods of on-going collaborative inquiry, which would complement the setting and monitoring of standards of care.

Through holding small-scale appreciative inquiries and discovery and action dialogues, wards and other multidisciplinary teams can generate and own cultural improvements within their own context, without external intervention. The templates for appreciative inquiry and discovery and action dialogue created through this evaluation can be used by any group of staff members to conduct a collaborative inquiry into their team culture. This method of inquiry supports learning and cultural improvement rather than the judgement implied by the cultural health check model, which could exacerbate and reinforce team deficits, particularly for teams in difficulty. It provides the reflexive space for teams to consider what works for them, in what context and how they can build on this to improve their culture. I believe that this is more likely to create a context of psychological safety to allow a group to surface and

escalate any concerns, than an individual staff member completing a checklist who may be subject to scapegoating or other forms of oppression.

I propose a practice model of creating a critically appreciative space, as represented by figure 8.1 below. This model is designed to support transition from a team deficit cycle through imbalances in power relations and interpersonal disharmony towards the establishment of a team appreciative cycle and a more positive team culture over time. The model provides conceptual containment for development practitioners when working through the inevitable struggle and emotional transference that occurs as old ways of being are let go, and new ways created and contested.

### **Preparing a collaborative inquiry**

- Development practitioner contracts with team leader and external manager about purpose and nature of collaborative inquiry: learning and improvement, not judgement
- Shares models of team deficit and appreciative cycles with them and importance of active constructive dialogue in creating a healthy leadership-followership dynamic
- Constructs situational analysis to surface range of elements and discourses in the situation - reviewed and reworked at each phase.
- Considers how and when basic assumption mode and work group mode operate.
- Maps front stage, back stage and off stage, planned and ad-hoc team interactions



### **Creating psychological safety**

- Development practitioner, team leader and manager acknowledge difficult situation openly with whole team without fear or anxiety
- Development practitioner ensures all team members included in meeting or series of meetings and that there is equality of voice in discussion
- Explains purpose of a collaborative inquiry and invites all team members' participation
- Creates reciprocity & relationality with the team by sharing own narrative, values and beliefs
- Team leader and manager offer future vision for the team and convey hope and trust in the positive core of the team. Distribute leadership to all team members.
- Development practitioner listens for positive experiences and feelings expressed by team and inquires about how these can be built upon.
- Acknowledges negative feelings of team members but does not engage with or reproduce team stories of deficit
- Notices stories relating to animating purpose of the team (likely to be linked to patient care)



### **Discovering the team's positive core**

- Development practitioner contracts with team members to create structure of collaborative inquiry with them, whilst they lead on providing the content
- Uses critical appreciative methods to discover best of what is and to create new knowledge as a basis for improvement
- Focuses on what works well for individuals and collect as many stories as possible
- Creates group discovery and action dialogue(s) using 1-2-4-Whole method
- Ensures equality of voice and sharing of multiple stories to encourage innovative power
- Listens for and focuses on moments of joy and meaning which are shared by individuals or the group as a whole
- Allows freedom of choice to participate
- Works with whomever participates and builds inquiry from this base - asks those present how they want to engage with those not present and encourages them to lead this process.



### **Team catharsis and integration**

- Team catharsis and integration is indicated by open recognition of the importance of team relationships and the team feels empowered to make changes.
- Team appreciative cycle becomes normalised.
- Learning and improvement reported by team members indicates that the team is no longer trapped in the deficit cycle.
- Team members display relationality, reciprocity and reflexivity in dialogue with each other, the development practitioner, team leader and manager.
- Development practitioner continues to check in with team members to support integration of the new way of being
- On agreement she disengages from the team with appreciation for the collaborative inquiry and their work in general.

**Figure 8.1. Practice model of creating a critically appreciative space**

A team deficit cycle creates a power vacuum whereby team members are unable to mobilize a range of mental, physical and emotional resources to achieve a sustainable social order. As the deficit cycle becomes entrenched, the system by which the team has hitherto survived begins to break down which increases the psychological threat. The first step in the model is to contain the anxiety created by system break down. This occurs through the creation of a psychologically safe relationship with the team through believing in the essential positive core of all the individuals and team involved. The development practitioner and external manager(s) seek to establish relationality and reciprocity through communicating how they plan to use their own knowledge and power, and narrating themselves into the team story.

The development practitioner initiates a collaborative inquiry that promotes the emergence of innovative thought in one-to-one and small group dialogues. This enables some team members to create new knowledge and new innovative power: *“the capacity...to create or discover new resources”* (Avelino and Rotmans, 2009, p552). This new knowledge allows them to see themselves and each other more constructively. Linking the innovative knowledge created by individuals together in a wider group discovery and action dialogue creates a transformative power whereby team resources are redistributed or replaced. In doing so the positive core of the team’s animating purpose can be rediscovered and new narrative knowledge and relationship bonds created. Team members employ these resources to establish a different and more harmonious way of being as they adopt a new social order. As the team becomes increasingly empowered to act, it enters a sustained appreciative cycle in which team members feel psychologically safe together and find joy and meaning in their work again.

The development practitioner in this model requires a range of knowledge and understanding. An appreciative development practitioner has a background in socio-psychological approaches to change and is able to work reflexively within group processes so that transference and counter-transference can be made conscious, understood and contained, rather than acted out unconsciously on participants. She has knowledge and understanding of the professional and organizational power dynamics of healthcare, of the particular context in which the team is situated, and aims to share and give away power to others. An appreciative development practitioner has an approach to change that is emergent, sensitive to micro-contexts, and focuses on the creation of psychological safety at all times. She approaches



team development and evaluation as a collaborative inquiry in which all perspectives are valid and treated with equal respect. She recognizes that expertise is situated within and between participants. She is appreciative of the team's animating purpose and positive core. Her role is both to support team members directly, and the team leader and external manager(s) to recognize that they hold positional power which they must be willing to distribute through engaging with the team in a democratic and participatory way. Through appreciative conversations with all involved, she contains basic assumption mode and engages with individual and group animating purpose.

As a result of this stance, an appreciative development practitioner finds little use for the paraphernalia generally associated with organization development, such as agendas, powerpoint presentations, flipcharts, diagnostic tools and models, checklists, and action plans; all of which demonstrate the power and expertise of the practitioner at the expense of participants. Group meetings are arranged at the most convenient time and location to clinical practice, in rooms set up with a circle of seats with no obvious lead position. Resources used are simple, everyday and focus on participants learning about each other's stories, sharing multiple perspectives, and collaborating and creating together on appreciative topics of their own choosing.

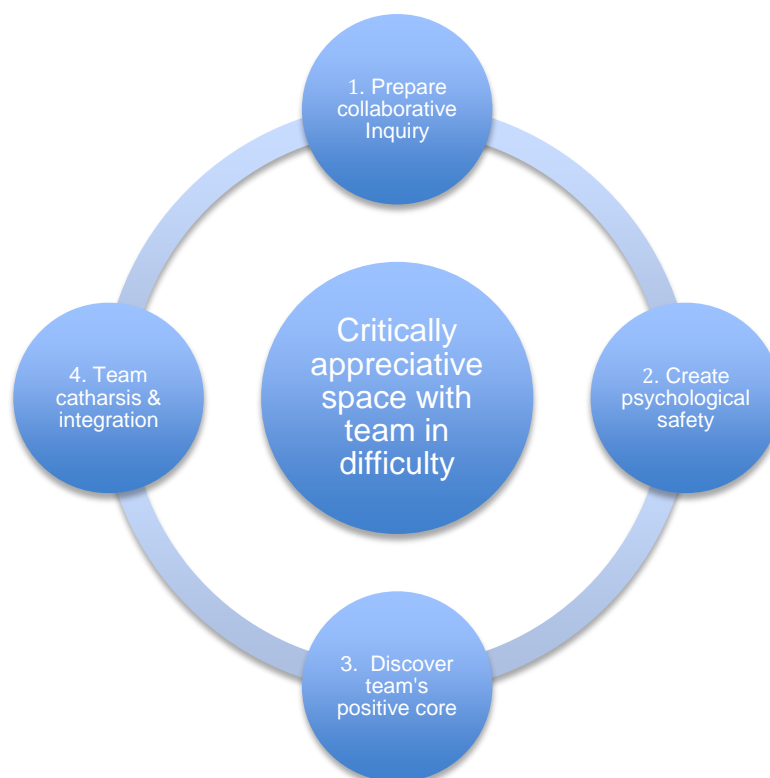
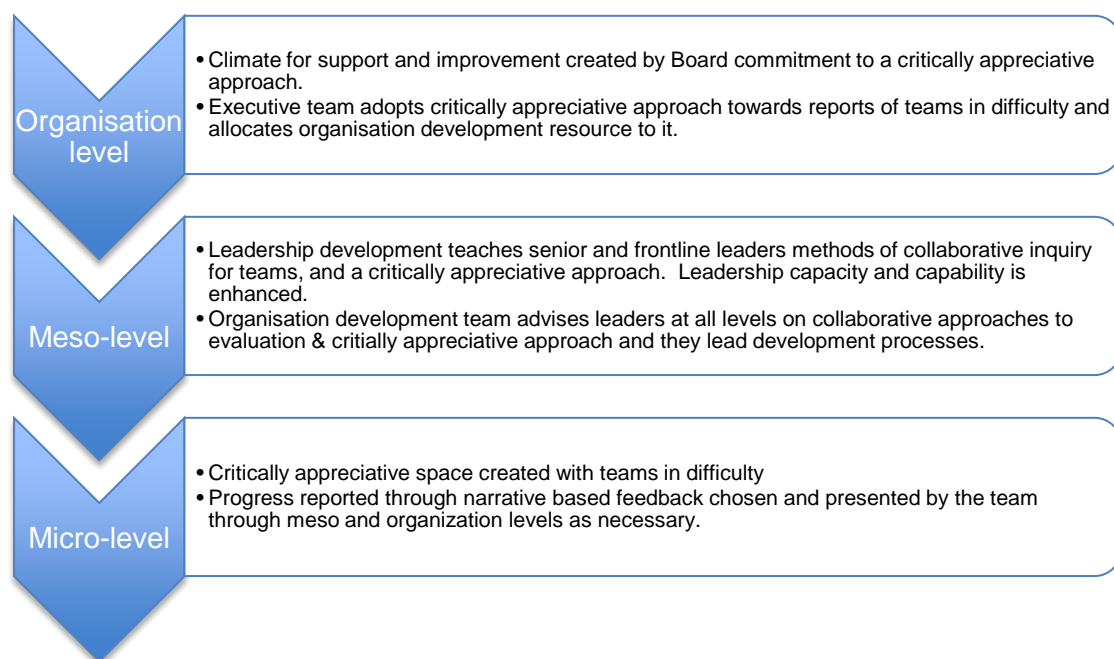
Adoption of collaborative inquiry involves a risk to change experts and managers in terms of surrendering power, control and position to others, who may have been identified as in difficulty in some way, but little risk in terms of staff and patient safety or use of precious resources. During the course of my research, I have questioned my legitimacy as an employee of the NHS and whether my contribution is valid, if I have no expertise to offer. Paradoxically, I have drawn the conclusion that my role is to preserve my own humanity in a system that often dehumanizes its staff and patients. This involves surfacing and understanding the socio-psychological defenses that lead me to ignore my own moral compass and can prevent me from operating with reflexivity, reciprocity and relationality on a day-to-day basis. This allows me to perceive the dynamic and systemic nature of my own socio-psychological position in the NHS. In doing so, I appreciate how challenging it is to stay well and connected as a frontline staff member, and continue to seek to share relational and narrative methods that support my colleagues in staying well and connected to themselves, to each other and to their patients.

## **Taking the model forward**

The model of creating a critically appreciative space as outlined in Figure 8.1 operates at group and individual levels of organization behaviour. In order to take the model forward, I have influenced the organizational level within my Trust, so that an organizational climate has been created whereby the micro-context work described in this report is permitted and embraced. Since conducting my research, I have presented a paper to the Trust Board called “Lessons Learned: Teams in Difficulty” on collaborative narrative based evaluations of staff experience, and the creation of critically appreciative spaces which have supported teams in difficulty to learn and improve. As part of their monitoring process, the Trust Board has requested regular story-based feedback from teams in difficulty so that they can appreciate their lived experience of development, rather than focusing only on quantitative performance data, in the same way that patient experience stories are reported at each Board meeting.

The model and methods included in this report have been included in all internal leadership development programmes, in order to create a psychologically safe meso-context for the creation of critically appreciative spaces in the micro-context. Through these programmes, and the on-going availability of support from the organization development team, senior and frontline leaders are empowered to hold collaborative inquiries and to understand how their behaviour contributes to creating an appreciative culture in the areas for which they are responsible. Previous ward managers and team leaders who have experienced a critically appreciative development experience are invited to present their learning and insights at internal and external leadership and patient safety improvement events.

I have presented my research at regional and national level and found that it resonated across different types of healthcare organization, suggesting that this approach could be adopted by non-acute healthcare organizations. Figure 8.2 below outlines the key organizational contextual factors required for adoption of this approach by healthcare organizations.



**Figure 8.2 Key organizational factors in support and improvement with teams in difficulty**

#### **Recommendation for further research**

This case study suggests that relationships with patients, whether remembered, imagined or actual, are a generative resource for frontline teams. It was outside the

scope of this project to explore this resource further. I recommend that future practitioner research into team development evaluates other interventions that involve frontline staff sharing stories with each other about their relationships with patients as a generative dialogue, such as Schwartz Center Rounds (Goodrich, 2012) and digital storytelling (Stacey and Hardy, 2011).

### **Significance of evaluation strategy**

The project's evaluation strategy was emergent employing reflexive, collaborative and iterative research methods. This allowed me to develop a series of evaluative phases, responding to the needs of participants and other stakeholders, as well as my own learning needs. I have learned that evaluation can be conducted with sensitivity to time and context and was built up in layers over the course of the project. In this way, the value of the project could be produced in different ways, both grounded and practical during its course, leading to more abstract and theoretical uses as patterns of data unfolded and were related to each other, and through a further iteration at its completion.

Questioning the data and chosen methods repeatedly was central to the development of a realist evaluation so that the interplay between context, mechanism and outcomes in relation to the intervention and evaluation could be formulated. This multi-layered evaluation was not evident within my original action research design, and was effectively generated by the project activity as I responded reflexively to unfolding findings and the questions these generated. The situational analysis provided an important contextual map and step in the evaluation, and appreciative inquiry and positive deviance approaches provided generative methods for the collaborative evaluation of teamwork. By adopting a bricolage approach to realist evaluation, I was able to use a wide range of knowledge available to me and to respond to the lived experience of working in the NHS. It is this lived experience in context that has been represented rarely in evaluations of healthcare teamwork and team development interventions. The emotional experience of the evaluation operated as a moral guide for the selection of methods and in its findings, as joy and meaning were found to be central to the engagement of the team with their patients and with each other.

The realist evaluation strategy was generative in a variety of ways. I used the context, mechanism and outcome framework to interpret the data from multiple methods in a way that generated new theoretical insights. Building theory in this

pragmatic and reflexive way was new and exciting to me. I was able to develop theory at a micro-level to support my choices as the evaluation progressed. The accumulation of micro-level theory led me to notice patterns and to question my assumptions about organization development practice and concepts of teamwork. Using this strategy, my retrospective insights and conceptual awareness expanded in relation to the project. Using the principles of realist synthesis I revisited the relevant literature at the end of the evaluation, which led me to critique organization development practice, to offer a new conceptualization of teams in difficulty, a realist evaluation framework for development practitioners working with teams in difficulty and a practice model of creating a critically appreciative space.

### **Reflections on learning knotting**

Becoming a practitioner researcher involved unlearning core elements of my professional practice, and learning about the nature of knowledge and power in the context of my workplace and the NHS more generally. I had not foreseen the turbulent emotional experience of conducting insider practitioner research, and was fortunate to have supportive personal and professional relationships. These were vital to my engagement with the complexity and uncertainty of the project and in questioning my deeply held and hidden professional assumptions. In doing so I became open to multiple discourses and interpretations of events. I learned that feeling lost was essential to the research process as it signaled that I was letting go of certainty and allowing ambiguity and different interpretations to emerge. Confronting that eighteen months of organization development intervention had been largely counterproductive was painful and I experienced intense anxiety about continuing the research. I believe that I entered a parallel process with participants at this point, whereby I had to confront my own practice errors and to find a way to continue without perpetuating the deficit cycle. This allowed me to empathize with their experience, and empathy provided the key to moving away from blame.

Working through what had happened helped me to align my practice (rather than my espoused practice) with my deep-rooted values. This involved changing direction, and experimenting with innovative evaluation methods both practically and theoretically. In doing so, I overcame my own scepticism and that of participants and other stakeholders. As the evaluation became truly directed towards learning and improvement rather than judgement, I became open to the possibility that the innovations would not work. This led to a degree of creativity and freedom that I had not experienced in my previous organization development practice. In sharing my

doubt and human vulnerability with the team, I gave away my power over them. Once I had done so, the evaluation became a collaborative inquiry, through which we could create, learn and change in relation to each other and to ourselves.

Through this project, I learned to narrate myself into my work, rather than hide behind a façade of neutral expertise. I have understood more deeply the nature and purpose of oral narrative in healthcare, and treat the stories I am told with greater respect, care and consideration than previously. I understand that the knowledge shared through stories is a valuable form of knowledge in working with team social process. In the doing of the project I learned how to work with the subtle interplay between individual and group narratives, including my own individual narrative in relation to the groups I join in the course of my work. I unlocked the joy and privilege of sharing in the high points of participants' experiences, and recognizing the rich emotional texture of the relationship between clinicians and patients. I learned about the skill and delicacy of the participants, and the managerial team who steered the team during the course of the project. Together they taught me about the nature of leadership, followership and change agency in action. I was tied up in tangled knots at the beginning of the project, and untied these throughout its course, in order to learn the gentle and appreciative craft of knotworking.

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**Trust R&D Approval letter**

Dear Mrs Stabler

**Re: STABLER 18/01/2012 – An action research approach to improving team culture  
in an Acute Hospital**

Thank you for submitting your application form to Research and Development.

Following review, it has been concluded that your work falls into the category of Service Evaluation and poses no unacceptable governance or ethical issues.

Therefore, R&D has approved your Service Evaluation and wishes you well with your study.

Kind regards.

A handwritten signature in black ink, appearing to read 'A Owens', is positioned above the printed name and title.

**Mr A Owens**  
Chairman of Research Approval Board  
GMC 3485934

HSESC Approval letter



School of Health & Education  
The Burroughs  
Hendon  
London NW4 4BT

Main Switchboard: 020 8411 5000

8<sup>th</sup> July 2014

To: Ms Amy Stabler. Re: Ethics Application No. 797 (November 2011)

Dear Amy

This application was approved by the Health Studies Ethics Sub-committee on 24th November 2011.

Yours sincerely

A handwritten signature in black ink, appearing to read "Karen Ridout", with a long horizontal flourish extending to the right.

Karen Ridout  
Department & Programme Admin Manager  
School of Health & Education  
Middlesex University

Reference

Date

Dear XXX

### **An action research approach to improving team culture in an Acute Hospital**

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

#### **What is the purpose of the study?**

The purpose of the study is to evaluate the process and outcomes of the intervention that has been taking place over the past eighteen months to improve team culture in your department. It will examine the impact of the intervention on the people involved, on the context of care for patients, and seek to identify improvements in organisation development practice. The products of the study will be:

- To test the theory behind the intervention and identify what works for whom and how
- To provide qualitative evidence of changes to complement quantitative measures already in place
- To provide a framework for evaluating future culture change interventions

#### **Why have I been chosen?**

All departmental staff, and the senior clinical and non-clinical managers involved in the intervention, are being invited to participate in the study so that a complete picture can emerge.

#### **Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time or a decision not to take part will not affect your staff rights or position in any way.

### **What do I have to do if I take part?**

You will be an active participant in evaluating the culture change in the department. This is an action research process whereby the researcher will consult with you and other participants to decide the key areas to evaluate, to evaluate these, and then to check that the evaluation reflects your experiences fully and accurately.

The study will entail three stages:

1. an individual hour-long interview;
2. a two hour focus group with 4-10 colleagues from department;
3. a two hour facilitated reflective session.

Each stage will take place in the Academic Centre at the Trust and will be tape recorded and transcribed. Timings will be arranged to suit your shift patterns. Each stage will take place at least a month apart with data analysis refined and shared with participants at each stage. The researcher may return to ask you follow up questions to check their understanding or interpretation of data collected. Follow up will also be arranged to suit you.

### **What are the possible disadvantages and risks of taking part?**

The study has been designed to be flexible and collaborative to minimise any risks to individual staff or the department. It is based in an approach of Appreciative Inquiry which aims to build on constructive experiences, rather than focusing on problems. In participating in collaborative research the process is uncertain but you can influence the findings and how these are presented.

### **What are the possible benefits of taking part?**

I hope that participating in the study will help you and the department to continue to change the culture in a way that benefits you. However, this cannot be guaranteed. The information gained

from this study may help other teams experiencing difficult cultural dynamics.

### **Will my taking part in this study be kept confidential?**

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name removed so that you cannot be recognised from it.

Data will be stored, analysed and reported in compliance with the UK Data Protection Act.

### **What will happen to the results of the research study?**

You will not be identified in any report or publication. The results of the research study will be shared with participants in the first instance, and then the Department as a whole, including any non-participants. It will then be shared with my Organisation Development colleagues to help inform and improve their practice and any findings that are relevant to the way that the Trust seeks to change culture will be shared at relevant Trust level meetings, such as the Organisational Capability Sub-Group that considers how best to develop staff. The research study will be published as part of my doctorate dissertation on culture change in healthcare settings and will be shared on the Trust's R&D Intranet site. This is likely to take place in 2012. The results will also be presented at national and international conferences as part of the Trust's research into organisation development practice. You can contact me for any internal or external published results or papers.

### **Who has reviewed the study?**

The study has been reviewed by the Trust's Research & Development Committee and Middlesex University, School of Health and Social Sciences, Health Studies Ethics Sub-Committee.

Thank you for taking part in this study.

Yours sincerely  
Amy Stabler  
Service Improvement Lead



Participant Identification Number:

## CONSENT FORM

**Title of Project:** An action research approach to improving team culture in an Acute Hospital

**Name of Researcher:** Amy Stabler

1. I confirm that I have read and understand the information letter dated .....for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
3. I agree that this form that bears my name and signature may be seen by a designated auditor.
4. I agree that my non-identifiable research data may be stored in National Archives and be used anonymously by others for future research. I am assured that the confidentiality of my data will be upheld through the removal of any personal identifiers.
5. I understand that my interview may be taped and subsequently transcribed.
6. I agree to take part in the above study.

\_\_\_\_\_  
Name of participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**Semi-structured interview guide**

Describe the Department's team culture.

What are the best aspects of the Department in your view?

What are relationships like in the team?

How do you feel about the Department at the moment?

What positive changes have occurred in the Department in the past 18 months?

Who is responsible for the changes you have seen?

How did they come about?

Did you feel part of the changes you have described?

How did those feelings affect your attitude towards the changes?

What are the key influences on the Department's culture now?

What influence do you have?

What would you like to see improve?

Describe the kind of workplace you would really enjoy.

What do you think that the Department needs to do to make more positive changes?

Would you be happy for a member of your family to be treated in the Department?

Is there anything else you would like to tell me?

## Coding Framework

Axial Codes	Open Codes	Raw data examples
Helping each other and being supportive	<p>Sticking together</p> <p>Helping ourselves</p> <p>Support for each other</p> <p>Small changes happen</p>	<p>All in this together</p> <p>Teamwork has improved</p> <p>Just got to get on with it</p> <p>We just get on, get the work done</p> <p>Everyone to get on</p> <p>You have to work as a team</p> <p>A lot of people who are very supportive</p> <p>Majority of us get on</p> <p>Because things happen slowly you don't notice little changes</p> <p>Little things, like everybody makes everybody a cup of tea</p>
Being fair and consistent	<p>Cliques</p> <p>Torn between being a team member and managing</p> <p>Equality of treatment</p>	<p>Friendship groups</p> <p>People supporting people that they're close to outside work</p> <p>Still the same clique</p> <p>Close to the people they're trying to discipline</p> <p>He wants to be everybody's friend</p> <p>I don't think he likes to confront people</p> <p>Lead by example</p> <p>Distant from the team</p> <p>People aren't treated the same by everybody</p> <p>I'd like everybody to be</p>

	Different rules for everybody	<p>equal</p> <p>It's got to be the same for everybody</p> <p>I don't think it's fair at all</p> <p>Always been one rule for one and one rule for another</p> <p>Everyone just does what they want</p> <p>Different rules for everybody</p> <p>Trusting me to be fair</p>
Being understood by people outside the department	<p>Secrecy</p> <p>Lack of trust</p>	<p>A lot of secrecy</p> <p>None of us knew anything about it</p> <p>I don't know who to believe</p> <p>Feel used</p> <p>We only heard bad things</p>
Enjoying clinical work	<p>Hassle free job</p> <p>Enjoying the work</p>	<p>Want to come here, do my job</p> <p>Do my job, go home</p> <p>No back-stabbing and talking behind your back</p> <p>It's a cushy job</p> <p>Most of us like our job</p> <p>We really enjoy our job</p> <p>We like working with patients</p> <p>I like the work</p> <p>Absolutely fascinating</p> <p>I've always liked it.</p>
Feeling proud of the quality of patient care	Patient care	<p>We always think about the patient first</p> <p>Patients get a really good service</p> <p>Patients get well looked after</p> <p>I don't think when there's patients there, there's any</p>

		tension
Protecting the department and the people who work in it	<p>Level of staffing</p> <p>Lack of professional respect for each other</p> <p>Bullying</p> <p>Guilt about betrayal</p>	<p>So short staffed</p> <p>Lost staff and they've not been replaced</p> <p>We haven't got any support from them in anything that we do</p> <p>He's quite rude to us all of the time</p> <p>People have no respect for the leadership</p> <p>A massive divide between the nurses and the AHPs</p> <p>A perception that the nurses don't do anything</p> <p>No respect for each other</p> <p>A huge blame culture</p> <p>It's nothing to do with you and keep your nose out</p> <p>Classic bullying and harassment</p> <p>People who are quite scared of him</p> <p>People like to blame him</p> <p>Felt like...we'd done something really horrible</p> <p>It was all our fault</p> <p>It felt a bit like a witch hunt</p> <p>The whole thing was just awful</p>
Wanting agreement about authority and standards	Needing an authority figure	<p>We need mother! We need a headmaster!</p> <p>He needs to be a bit more of a leader really</p> <p>Zero leadership</p> <p>The manager should pick it</p>

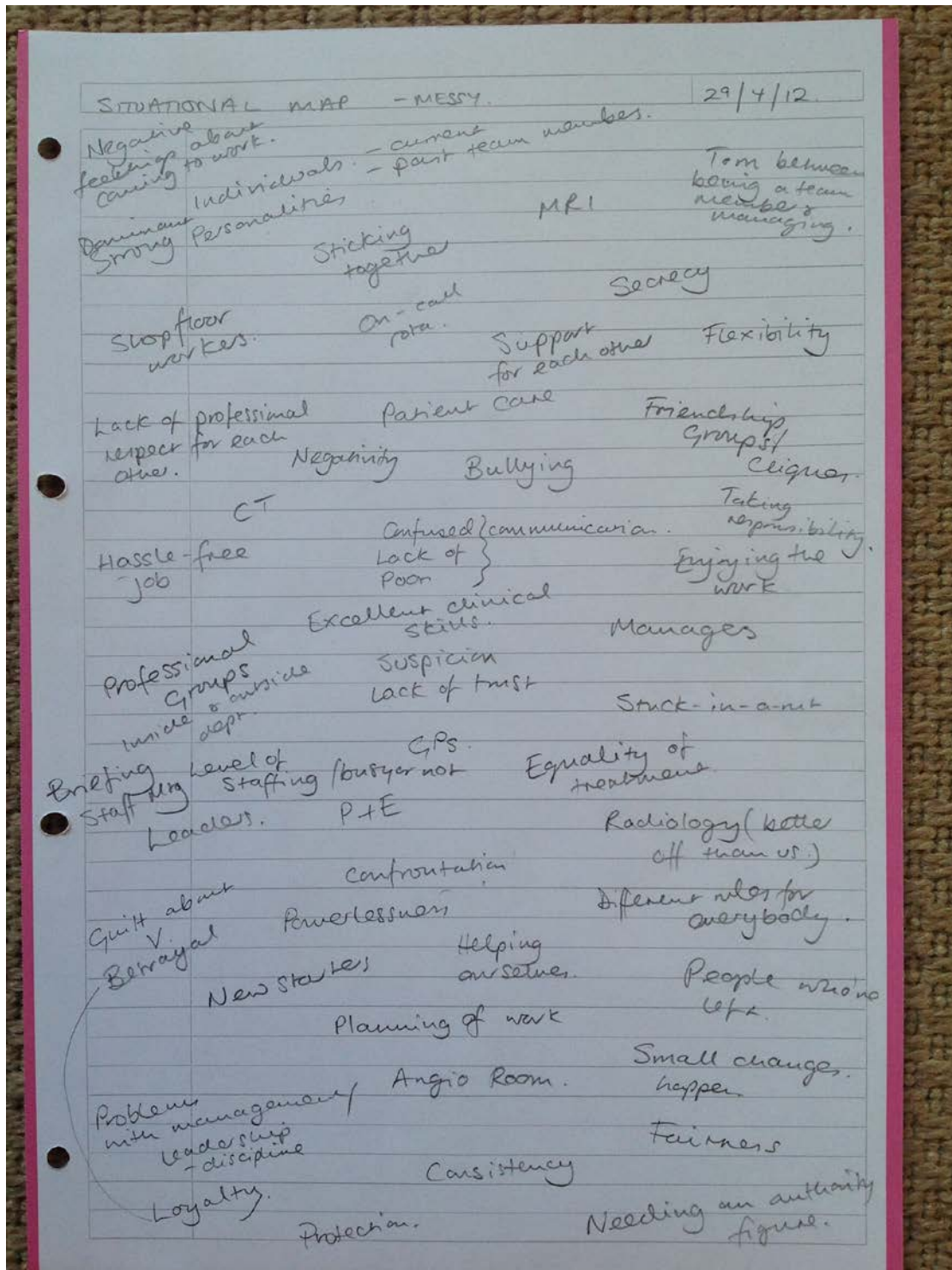
	<p>Confrontation</p> <p>Planning of work</p> <p>Confused communication</p>	<p>up</p> <p>People need to be a bit more spoon fed</p> <p>They would love a really strict manager</p> <p>A ball breaker</p> <p>Personality clashes</p> <p>They had quite a heated argument over it</p> <p>People refusing to support each other and don't help each other</p> <p>He got quite angry and upset</p> <p>Nothing's planned</p> <p>Every day it's chaos</p> <p>I always feel out of the loop"</p> <p>Trouble with communicating</p> <p>Won't make any decisions</p> <p>Hitting your head on a brick wall</p> <p>Nobody knew anything about it</p> <p>I don't think it's being communicated</p>
Picking up problems and sorting them out	<p>Strong personalities</p> <p>Taking responsibility</p>	<p>A lot of stuff is to do with personalities</p> <p>Strong personalities</p> <p>Everyone's frightened to say anything to her</p> <p>It's not being challenged</p> <p>I'd like to be able to work somewhere with grown ups</p> <p>I think we need to stick to the rules</p> <p>Lose the people who are</p>



	Stuck in a rut	<p>You'll soon get sick and be like us</p> <p>They're all just stuck in a rut</p> <p>You just all get set in your ways</p>
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## Messy Situational Map



## **Ordered Abstract Situational Map**

### **Individual Human Elements/Actors**

Individuals inside the department

Individuals outside the department but regularly interacting with it

### **Collective Human Elements/Actors**

Professional groups

Friendship groups

Managerial groups

Groups involved in specific technical procedures

External departments

New starters

Academic advisers to the research

### **Discursive constructions of individual and/or collective human actors**

Social world construction of professional groups

Social world construction of friendship groups

Social world construction of managerial groups

Social world construction of external departments

Clinical world construction of professional groups

Clinical world construction of managerial groups

Clinical world construction of external departments

Patient experience as constructed by all collective human elements

Narratives of the department's history

Narratives of the department's future

### **Political/economic elements**

Search for productivity and efficiency savings

Threat to survival of division in face of competition from other Trusts for business and recruitment problems

Economic threats to individual jobs/pay/pensions

Few other employment options in local health economy

### **Temporal elements**

Need to make significant savings this financial year

**Major issues/debates (usually contested)**

Trust - internal and external relationships

Fairness and consistency of treatment

Respect between colleagues

Authority relationships

Role boundaries

Social responsibilities

Relationship with radiology department

Constructive communication

What does “busy” mean?

Openness

Planning

Service improvement

Access to training opportunities

**Other kinds of elements****Nonhuman elements/actants**

Clinical protocols

Organizational policies

Professional codes

Portering

Treatment machines

Computers

Phones

Uniforms

**Implicated/silent actors/actants**

Patients

People who have left the department

GPs

Families of staff

**Discursive construction of nonhuman actants**

Homelife

**Sociocultural/symbolic elements**

Provision of high quality, safe, patient-centred care

Clinical work is enjoyable

Department as “victim”

The NHS is becoming a more stressful place to work

**Spatial elements**

The department as physical space

Physical spaces shared between staff and patients

Physical spaces shared between staff only

Physical spaces for patients to wait in

Physical spaces assigned to individual staff

Email as an electronic space for communication

**Related discourses (historical, narrative, and/or visual)**

Organizational discourses – formal and informal

Leadership discourses in healthcare

Teamwork discourses in healthcare

Service Improvement discourses in healthcare

Change management discourses

Discourses on professionalism in healthcare

Media discourses about the NHS

## Appreciative Inquiry

### Pilot question protocol

1. Think of a really positive experience or “high point” in your work as a member of this team. Describe what made this a good experience for you.

.....

.....

.....

2. Think of another particularly successful team you have been a member of? What made this team a good environment for you to be in? (*prompt: team from inside or outside work/non-work*).

.....

.....

.....

3. In these experiences what were the things you most valued about i) yourself; ii) the others involved; and iii) the context/setting that enabled the team to be successful?

- i. Yourself

.....

.....

.....

ii. The others involved

.....

.....

.....

iii. The context/setting

.....

.....

.....

4. What was motivating or inspiring about these experiences?

.....

.....

.....

5. If you could make three positive changes that would ensure that the current team was always like this – what would they be?

i.....

.....

.....

ii.....

.....
.....
iii.....
.....
.....

### Paul's Story

Bringing in the business from the pain team came from us really working together as a team.

I had been working in theatres with Brian Watson. He told me I'd done a good job for him; I rate him because he doesn't suffer fools gladly. This gave me the confidence to convince him that we could do the work.

It started off in the Ultimex room and then developed in the Angio room, as staff wanted it in there and it's a nicer room.

It was a bit of a change because we have patients in for a lot longer and it doesn't always run smoothly. But everybody's talked it out and said "look can we change the way the list is booked? Can we stagger them, instead of bringing them all en masse?" That was nurse-led. They picked it up and made it better.

And it snowballed from there with Graham Turner coming down and doing lists. And they're really nice people to work with. I'm not there all the time, I don't even work in the Angio room. It's what we do together and it works really well. It's making people feel better as a team, and it's bringing business in.

What's so motivating is that we can do things we've never done before with very little difficulty, just a bit of thought.

#### **What worked well for me?**

People having a positive attitude and wanting to change things.

The success was all down to people working together.

Being appreciated for doing a good job gave me the confidence to show what we could do to others.



## **John's Story**

I believe that the whole point of being here is to look after patients; to look after them to the best of our ability.

When a patient turns up with a haemorrhage and they need an angio. They have their CT scan and we say "right, that's what you need". We embolise the patient and it may take six hours, til half past seven at night. That is very satisfying. Even though I'm tired, I just am pleased, satisfied and happy with what I'm doing. The patient has the treatment they need.

At these moments, it feels as though everybody is doing things for the same reason as I am, all pulling in the same direction. Everybody is confident in their role and we work interchangeably. We have clarity.

I get job satisfaction from carrying out the job that I'm here for, and doing the best that I can. When it works well, it motivates me to keep trying to get it working well all the time.

### **What worked well for me?**

The team caring about people, and empathizing with the patient.

People were generous and willing to give of their abilities.

Everybody fully understood and appreciated the roles that everybody else played in the team.

## **Kathryn's Story**

Trevor, Kate, Michelle and I were ready for our first clot retrieval in the Angio Room.

I was the runner that day and we were excited to do it because it was the first one.

The patient came in with a horrendous angiogram. We could actually see that the vessels were blocked from the clot.

Obviously it was stressful at the time. The stroke consultant was there as well.

We actually saw the clot retrieved and put in a little bowl of water, and then we watched the blood flow back up to the brain, which was incredible.

We were so proud of Trevor and all clapped him at the end.

It was a lovely experience, I felt like a proper team. When you gain that result at the end for the patient it just makes you feel good about yourself.

### **What worked well for me?**

Working in the room, thinking about what the other person wants, to back each other, being there so it all runs smoothly

Others staying to help afterwards at the end of a case.

Acknowledging when we have done a good thing, saying thank you to each other

Working closely as a team, asking and checking that everyone is available beforehand.

## **Louise's Story**

I feel proud of my work here when we are providing something good for the patient. Those are high points for me.

Thinking about a successful team I have experienced outside work: I was running as part of a team for Breast Cancer in the local 10K. Everyone helped each other to complete this, no matter what strengths or weaknesses they had.

It was a great experience helping others overcome their weaknesses. People also helped me when I was struggling. All the other teams around us were encouraging us too.

We all shared the ultimate goal to do good for other people, including our family members.

## **What worked well for me?**

Excellent communication

Being aware of and caring for team colleagues

Recognition of pressures on us by people outside the immediate team

**Written data collected from Discovery and Action Dialogue**

**What have you discovered through reading the stories around the room?**

1. Working together usually leads to a positive outcome.
2. People appreciate recognition of their effort or talent.
3. All staff share commitment to making the department work and assist the patient to the best of their ability
4. Everybody thinks it goes well when we work together as a team
5. People feel happy when they feel they have worked well as part of the team and that their work was appreciated.
6. People are happy when they have achieved a good result for patients.
7. The majority of experiences express helping others and being helped themselves as part of a team where everyone knows their roles and limits

**What do you appreciate about the positive core of you and your colleagues?**

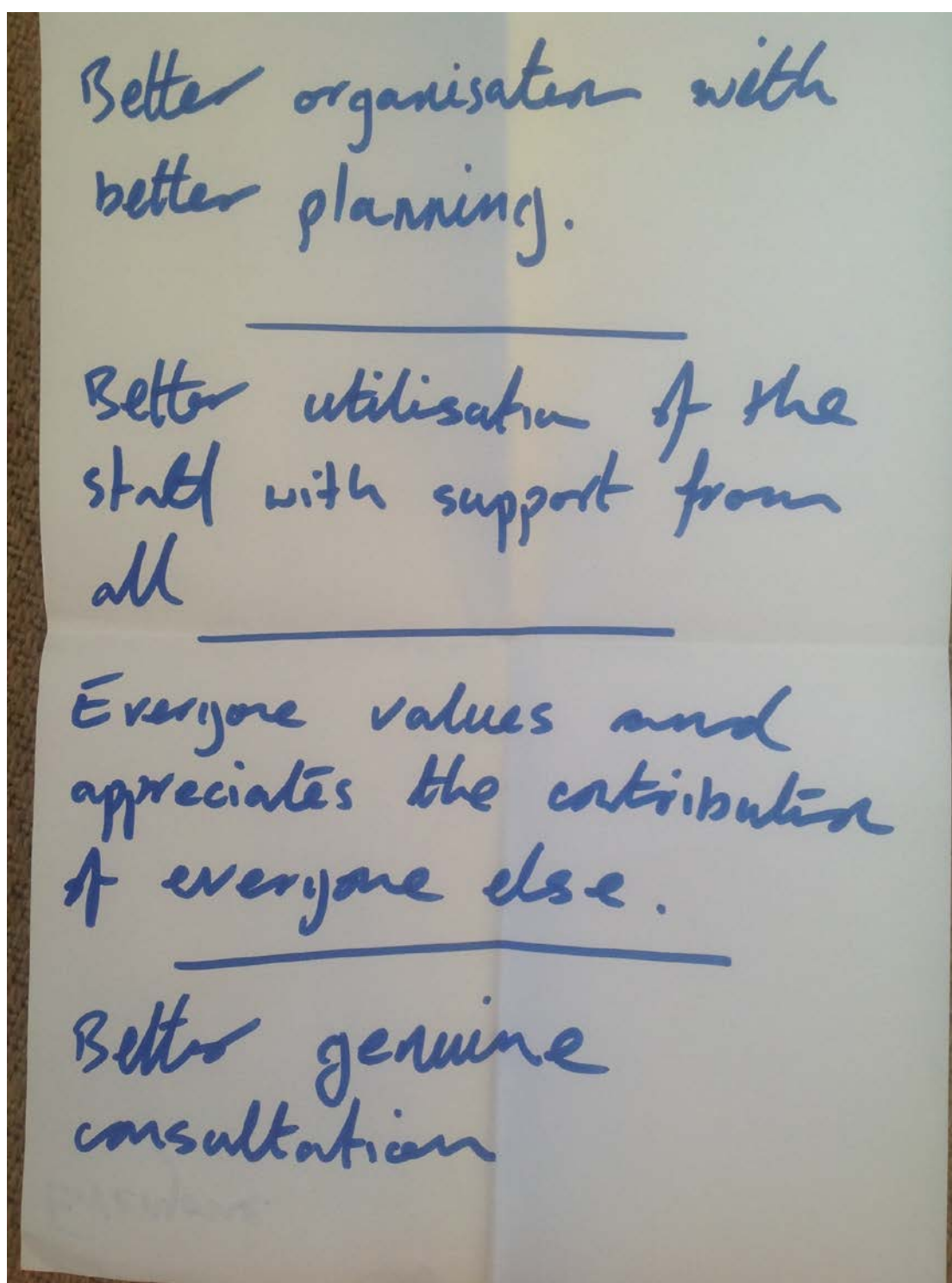
1. No surprises. Constant two-way communication with confidence and trust in each other.
2. The need to recognise, acknowledge and compliment people in their achievement.
3. Teamwork essential.
4. Communication. Staff are willing and determined. Everyone is focused and patients come first.
5. Everyone works hard, together. Commitment is obvious from all stories.
6. Patient oriented, everyone thinks it is good when the patient is central to what we do
7. A hard working valued team striving to give the patient the most best possible experience whilst they are here.
8. Patient care is the ultimate goal

**What would this department look like if it were designed in every way possible to maximise the qualities of this positive core – what would you experience?**

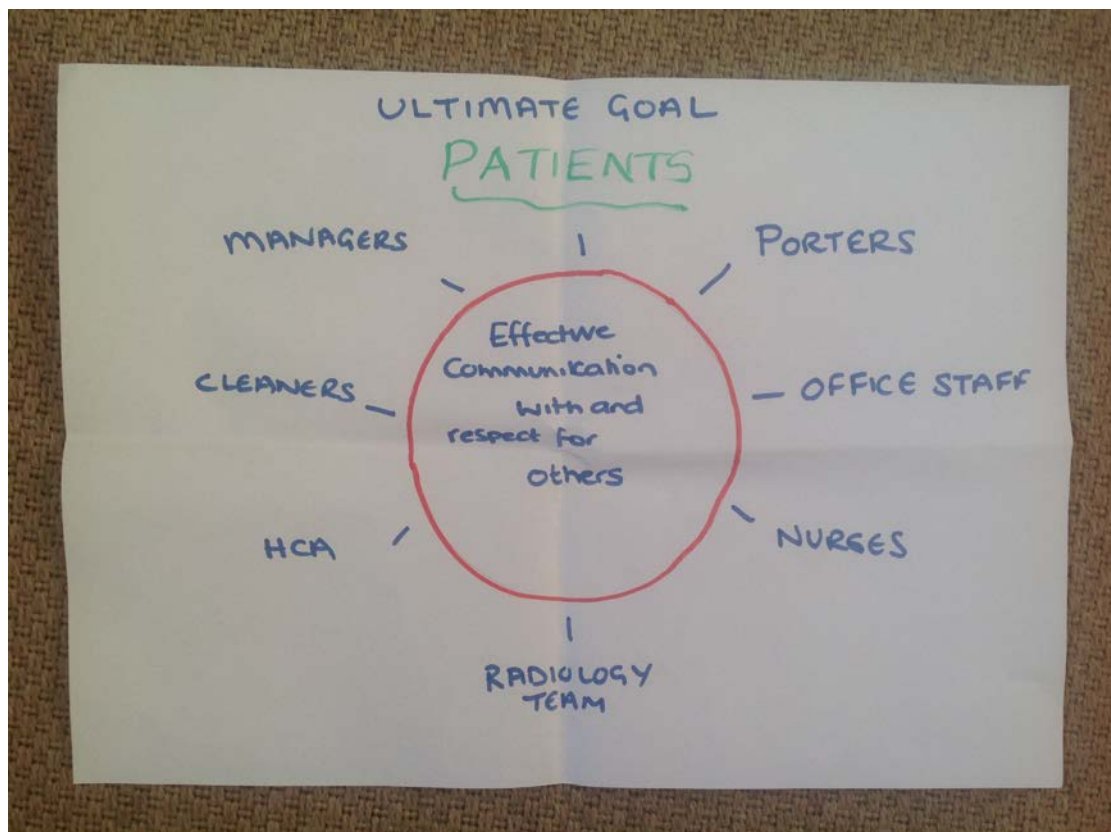
1. Each team member would feel as if they were making a valued contribution.
2. Would need more staff.
3. Experience better quality of life at work - would reflect in general well being outside work

4. Happy staff and patients. Supportive enthusiastic staff. Smoother running service.
5. More staff at a lower level to let you get on with the job we do instead of clerical stuff
6. Stop putting us in situations that provoke arguments and bad feeling
7. I would experience being valued, appreciated for hard work. To be listened to if I have any thoughts and ideas as to how the department can move forward and to put these into practice.
8. More staff
9. Everyone would feel respected and appreciated
10. This would be reflected in people's work leading to improved patient experience
11. Everyone positive and supportive of other people
12. People concentrating on their own job and not others' leading to improved patient care
13. Better communication
14. Support, recognition from colleagues
15. Support staff assisting for the ultimate goals
16. A happy team, encouraging, supporting.
17. Patients having a good experience

32 written statements collected from seven participants.



Discovery & Action Dialogue Figure 1



Discovery & Action Dialogue Figure 2



## Coding Framework including discovery and action dialogue data

Axial Codes	Open Codes	Raw data examples	DAD raw data
Helping each other and being supportive	<p>Sticking together</p> <p>Helping ourselves</p> <p>Support for each other</p> <p>Small changes happen</p>	<p>All in this together</p> <p>Teamwork has improved</p> <p>Just got to get on with it</p> <p>We just get on, get the work done</p> <p>Everyone to get on</p> <p>You have to work as a team</p> <p>A lot of people who are very supportive</p> <p>Majority of us get on</p> <p>Because things happen slowly you don't notice little changes</p> <p>Little things, like everybody makes everybody a cup of tea</p>	<p>Working together usually leads to a positive outcome</p> <p>People appreciate recognition of their effort or talent</p> <p>Everybody thinks it goes well when we work together as a team</p> <p>People feel happy when they feel they have worked well as part of the team and that their work was appreciated</p> <p>The majority of experiences express helping others and being helped themselves as part of a team where everyone knows their roles and limits</p> <p>No surprises.</p> <p>Constant two-way communication with confidence and trust in each other</p> <p>The need to</p>

			<p>recognise,  acknowledge and  compliment people  in their  achievement  Teamwork  essential  Communication  Staff are willing  and determined  Everyone works  hard, together  Commitment is  obvious from all  stories  Support,  recognition from  colleagues  A happy team,  encouraging,  supporting  A hard working  valued team</p>
Being fair and consistent	<p>Cliques</p> <p>Torn between  being a team  member and  managing</p>	<p>Friendship groups  People supporting  people that they're  close to outside  work  Still the same  clique  Close to the people  they're trying to  discipline  He wants to be  everybody's friend</p>	<p>Everyone would  feel respected and  appreciated  Everyone positive  and supportive of  other people  Better  communication  All staff share  commitment to  making the  department work</p>

	<p>Equality of treatment</p> <p>Different rules for everybody</p>	<p>I don't think he likes to confront people</p> <p>Lead by example</p> <p>Distant from the team</p> <p>People aren't treated the same by everybody</p> <p>I'd like everybody to be equal</p> <p>It's got to be the same for everybody</p> <p>I don't think it's fair at all</p> <p>Always been one rule for one and one rule for another</p> <p>Everyone just does what they want</p> <p>Different rules for everybody</p> <p>trusting me to be fair</p>	<p>and assist the patient to the best of their ability</p>
<p>Being understood by people outside the department</p>	<p>Secrecy</p> <p>Lack of trust</p>	<p>A lot of secrecy</p> <p>None of us knew anything about it</p> <p>I don't know who to believe</p> <p>Feel used</p> <p>We only heard bad things</p>	
<p>Enjoying clinical work</p>	<p>Hassle free job</p>	<p>Want to come here, do my job</p>	<p>People are happy when they have</p>

	Enjoying the work	<p>Do my job, go home</p> <p>No back-stabbing and talking behind your back</p> <p>It's a cushy job</p> <p>Most of us like our job</p> <p>We really enjoy our job</p> <p>We like working with patients</p> <p>I like the work</p> <p>Absolutely fascinating</p> <p>I've always liked it.</p>	<p>achieved a good result for patients</p> <p>Patient oriented, everyone thinks it is good when the patient is central to what we do</p> <p>Happy staff and patients.</p> <p>Supportive enthusiastic staff.</p> <p>Smoother running service.</p> <p>More staff at a lower level to let you get on with the job we do instead of clerical stuff</p> <p>People concentrating on their own job and not others' leading to improved patient care</p>
Feeling proud of the quality of patient care	Patient care	<p>We always think about the patient first</p> <p>Patients get a really good service</p> <p>Patients get well looked after</p> <p>I don't think when there's patients there, there's any tension</p>	<p>Striving to give the patient the most best possible experience whilst they are here.</p> <p>Patient care is the ultimate goal</p> <p>Everyone is focused and patients come first.</p> <p>This would be</p>

			<p>reflected in people's work leading to improved patient experience</p> <p>Support staff assisting for the ultimate goals</p> <p>Patients having a good experience</p>
Protecting the department and the people who work in it	<p>Level of staffing</p> <p>Lack of professional respect for each other</p> <p>Bullying</p> <p>Guilt about betrayal</p>	<p>So short staffed</p> <p>Lost staff and they've not been replaced</p> <p>We haven't got any support from them in anything that we do</p> <p>He's quite rude to us all of the time</p> <p>People have no respect for the leadership</p> <p>A massive divide between the nurses and the AHPs</p> <p>A perception that the nurses don't do anything</p> <p>No respect for each other</p> <p>A huge blame culture</p> <p>It's nothing to do</p>	<p>Each team member would feel as if they were making a valued contribution.</p> <p>Would need more staff.</p> <p>Experience better quality of life at work - would reflect in general well being outside work</p> <p>I would experience being valued, appreciated for hard work. To be listened to if I have any thoughts and ideas as to how the department can move forward and to put these into practice.</p> <p>More staff</p>



	Confused communication	<p>People refusing to support each other and don't help each other</p> <p>He got quite angry and upset</p> <p>Nothing's planned</p> <p>Every day it's chaos</p> <p>I always feel out of the loop"</p> <p>Trouble with communicating</p> <p>Won't make any decisions</p> <p>Hitting your head on a brick wall</p> <p>Nobody knew anything about it</p> <p>I don't think it's being communicated</p>	
Picking up problems and sorting them out	<p>Strong personalities</p> <p>Taking responsibility</p>	<p>A lot of stuff is to do with personalities</p> <p>Strong personalities</p> <p>Everyone's frightened to say anything to her</p> <p>It's not being challenged</p> <p>I'd like to be able to work somewhere with grown ups</p> <p>I think we need to</p>	





	Stuck in a rut	<p>Some days are worse than others</p> <p>If one person starts moaning it's like dominoes</p> <p>We all still have a moan</p> <p>You just feel like you're wasting your time</p> <p>There's a lot of tension and bad feeling</p> <p>Negativity can be crippling some days</p> <p>I can't stand the negativity down there</p> <p>You'll soon get sick and be like us</p> <p>They're all just stuck in a rut</p> <p>You just all get set in your ways</p>	
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